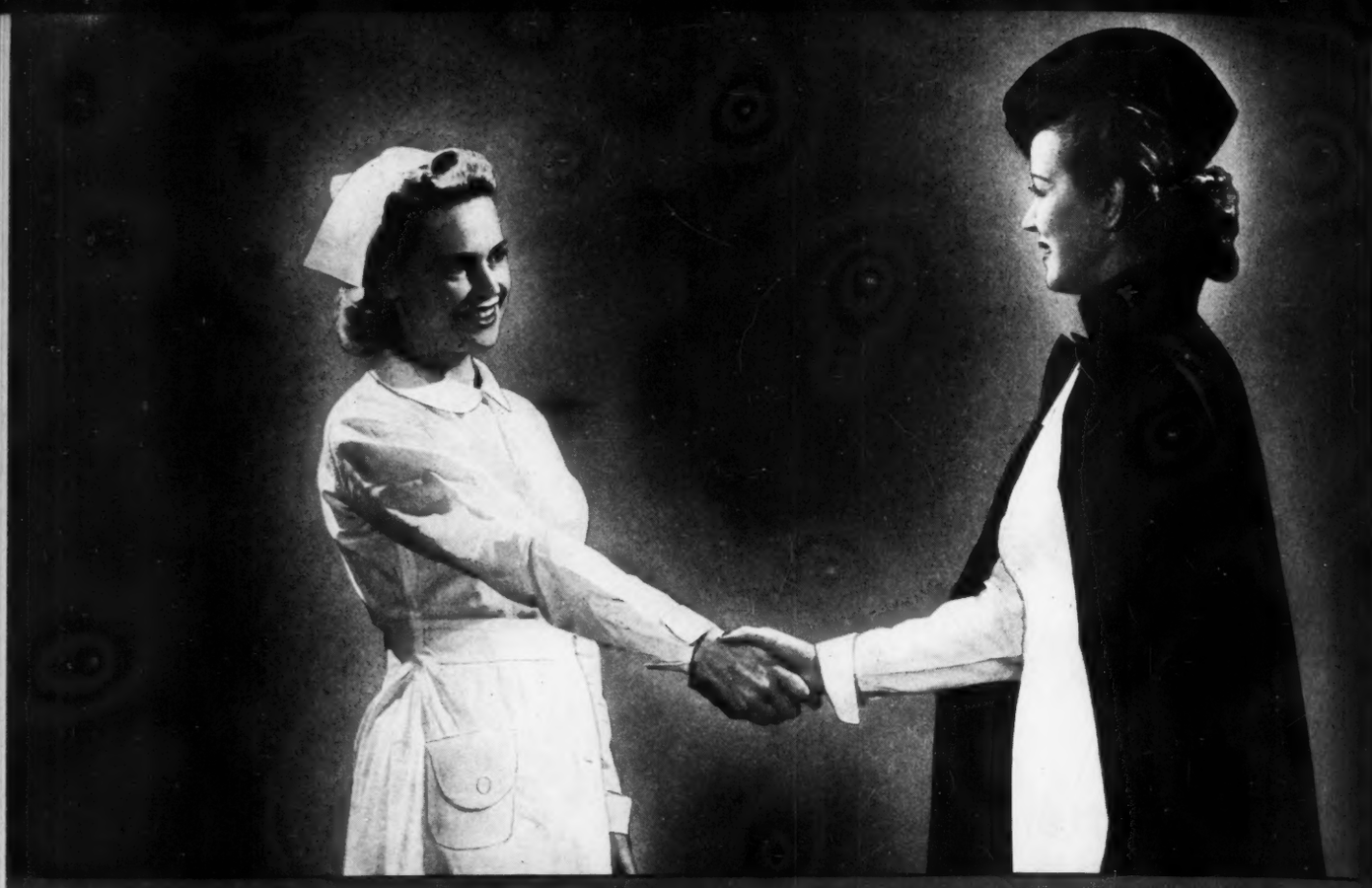
JUN 2 1941

Hospital Library

the MODERN HOSPITAL

VOLUME 56 JUNE 1941 NUMBER 6



SCENE: Any hospital corridor—Anywhere in the U. S.

TIME: Now

Nurse-in-White: "So long, Mary. I don't know what we'll do without you."

Nurse-in-Khaki: "Don't be silly. Haven't you heard about the new system?"

Nurse-in-White: "What new system?"

Nurse-in-Khaki: "They're putting in one of those new phone systems so you can talk with the patients right here at the station. Now when 412 wants a drink, you just send an orderly, and save your own shoe leather for the real jobs. It'll be a cinch for you. I'm the one that will be doing the foot work from now on."

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Just in Passing—

WITH temperatures rising, the suggestion that hospitals begin planning their winter's work may seem premature. We hold that the midsummer MODERN HOSPITAL is the proper time and place for the discussion of winter programming. Therefore, you may anticipate in July many helpful articles on planning activities for the months in which it is safe to eat fresh oysters.

UNCERTAIN conditions arising from the national defense effort may seem to furnish those administrators who do not operate on a budget the excuse they have been looking for to procrastinate on the matter. On the contrary, these very uncertainties make it imperative that all hospitals obtain the assurance and safety that a properly devised and administered budget will achieve. How to use a budget during changing conditions will be a July feature.

BEFORE an administrator can prepare a budget that means anything, he needs to know what he is going to be "up against" in the way of salaries and costs of new equipment. Methods of surveying the probabilities in both of these fields are to be outlined next month.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
.....	.....	.....
.....	.....	.....

Return to.....

The Modern Hospital

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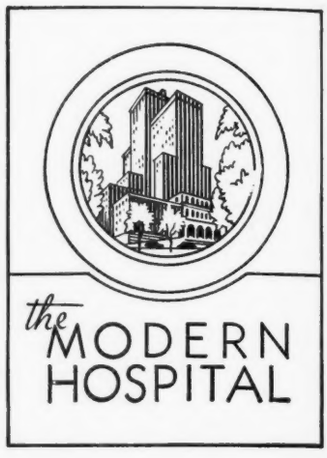

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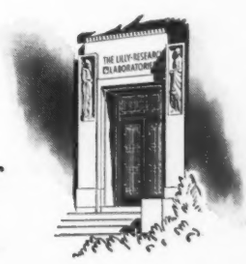
Reaping the Benefits of Medical Research

● Not so many years ago diabetes was fatal. A diagnosis of pernicious anemia was a sentence to death. There was little relief for allergy. Endocrine and vitamin therapy were unheard of. Then came medical research, not new, but more intensive. Diabetes and the anemias can now be controlled. There is help for the allergic. New chemotherapeutic agents have been discovered. Many of the terrors of pneumonia and other streptococcic infections have been eradicated. Thousands of lives have been saved, millions of periods of illness shortened. Every patient, these days, reaps the benefits of medical research.

For many years Eli Lilly and Company has been among the leaders in medical research. The Lilly organization was selected to co-operate with the original investigators in the commercial development of Iletin (Insulin, Lilly), liver extract, and ephedrine. It was our good fortune to be the first to introduce these important agents to the medical profession of the United States. In the study of barbiturate derivatives we have also been active. In this field, 'Seconal' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly) is the choice of many physicians. 'Seconal' is especially recommended in insomnia due to nervousness, extreme fatigue, and in similar conditions where only a short sedative effect may be required to induce natural sleep.



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"Poly's" Coffee Shop

• Hardly were the doors of the Poly Coffee Shop in Polyclinic Hospital, New York City, thrown open to the public when business started with a rush. That was but a few weeks ago, and already it looks as though Supt. A. A. Jaller and his associates had been conservative in estimating the space required. Yet the shop boasts a capacity of 55, with a counter accommodating 13.

What an attractive room this is with its walls finished in pale pink against which are painted the slender trunks of white birch trees! The decorative scheme is distinctly modern with furniture of bleached wood, Swedish maple to be exact, and upholstery pads of blue and yellow.

The purpose is to sell the best food possible at the lowest prices. On the day your Roving Reporter stopped in, the shop's "special" was hot turkey sandwich, giblet gravy, cranberry sauce, coleslaw and coffee, all for 40 cents. There was also a cold meat platter with mixed salad, rolls and coffee for 45 cents. Desserts and soups average 15 cents. There are combination breakfasts, too, ranging in price from 15 to 40 cents, for the shop is open from 8 a.m. to 10 p.m. A charge of 10 cents is made for tray service to rooms.

What took the eye of one visitor was the tea bag with a tag bearing on one side the name, "Poly Coffee Shop," encircling a parrot, and on the other side the words, "The hospital with the homelike atmosphere."

Meeting at the Polyclinic Hospital's picturesque new coffee shop provides a pleasant social interlude for busy personnel as well as hospital visitors.

In the Event of Fire

• Orange Memorial Hospital, Orange, N. J., has been the scene of tests conducted to show the public what to do in the event of fire. A brick and cement block building entirely separate from the buildings of the hospital in which patients are housed was the scene of the activity.

It was discovered by Charles K. Farrington, public relations director, that some of the simplest articles, such as a blanket and water in a pitcher, if intelligently used, will extinguish flames. The possibility of removing a burning bed cover before it is consumed entirely and of smothering the flames by covering the burning portion with the unburned portion was demonstrated also. By utilizing the correct methods, hospital employes can put out such fires without setting their own clothing on fire and without burning themselves, the tests proved.

Mr. Farrington found from making these tests that the time required to extinguish such fires was of the greatest importance, for flames often spread rapidly if not quenched. Hence those hearing a cry, "My clothing is on fire, help," should immediately obtain a blanket and water in a pitcher. If a blanket is not available, some other form of covering, such as a heavy curtain, coat or even a small rug, will suffice; if a pitcher of water cannot be found readily, a pail or some other receptacle can be used.

To bring this information to the attention of the public seven nurses were photographed showing what they had learned from the tests. These pictures, accompanied by suitable descriptive matter, were then released to the local papers.

Another House Magazine

• They call it *The Spotlight* at Glens Falls Hospital, Glens Falls, N. Y. It's another of many little house magazines that are appearing from time to time, making friends within and without the hospital. Each issue is dedicated to a special department, such as the medical department and the nursing staff. Each issue, too, contains an organization chart, which keeps the plan of operation constantly before the eyes of every employe.

Another interesting feature of the magazine is a listing of all staff and employe meetings for the succeeding month.

Bulletin of Bouquets

• Every hospital receives brickbats now and then, but what about the bouquets handed it by enthusiastic patients. The Lenox Hill Hospital, New York, offers something of interest to everyone who wants to make the personnel feel that life is worth living after all. John Hayes has a little publication called "Bouquets" which he posts regularly in various spots about the building so that all the workers may see them.

For example, those who care to read may learn that Vivian Schloss, who was a patient on "semiprivate 7," wrote as follows: "This from a patient who, pre-Lenox Hill, was frankly wary of hospitals. Never having been hospitalized before, I expected cold white walls and treatment of the same frigid manner. I was in for a surprise. From the time I entered to the day I regretfully left I can say I had none but the finest of treatment, care and interest in my case. Everyone with whom I came in contact was of the pleasantest sort. Their work was done good-humoredly, yet never to the sacrifice of one whit of efficiency."

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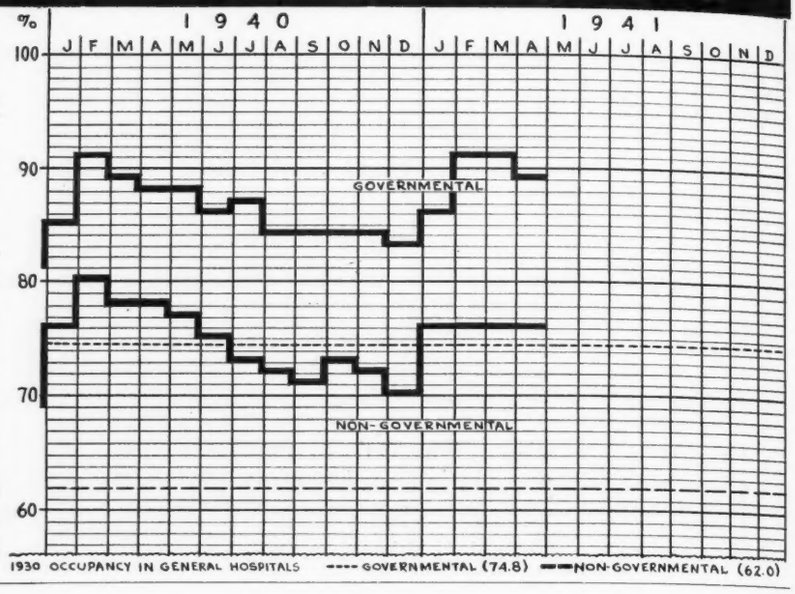
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1941: April	1941: Mar.	1940: April	1940: Mar.
Governmental:						
New York City	17	10,380	107*	107	112	100
New Jersey	5	2,136	94*	94*	84	98
N. and S. Carolina	20	2,655	75*	77	75	74
New Orleans	2	3,422	82	82	75	75
San Francisco	3	2,255	100	108	101	102
St. Paul	1	850	72*	70	74	81
Chicago	2	3,500	90*	90*	96	94
Total[4]	50	25,198	89*	90*	88	89
Nongovernmental:						
New York City[3]	70	16,526	69*	69*	82	80
New Jersey	56	8,111	80*	80*	68	71
N. & S. Carolina	109	7,913	67*	68	69	70
New Orleans	6	1,233	75*	85*	76	84
San Francisco	16	3,178	80	81	78	78
St. Paul	9	1,134	84*	87	95	89
Chicago	28	5,870	76*	77	69	69
Cleveland	15	3,085	79*	80	85	84
Total[4]	309	47,050	76*	78*	78	78

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



April Occupancy and Construction Were Extremely High

Preliminary figures on the occupancy of the nongovernmental general hospitals indicate that they continued to be extremely busy during April. Revised reports for March have raised the occupancy figure for that month so that it now equals the figure for a year ago.

The data now available for April indicate a two point loss from the 1940 figure, but this may change as further reports are received. In any event an occupancy of 76 per cent is high. In 1939 the occupancy in these hospitals was 74 per cent, in 1938 it was 72 per cent and in 1937, 74 per cent.

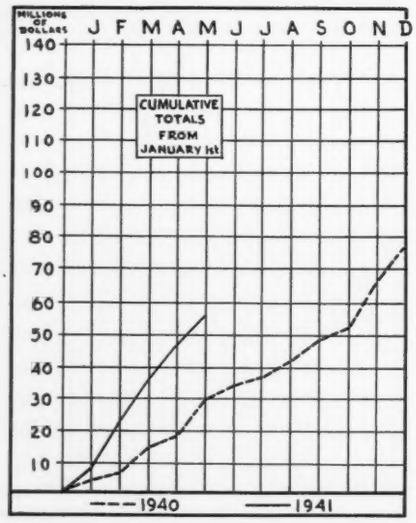
In the governmental general hospitals, preliminary reports also showed a slight drop from the high figure of March and February. The April figure of 89 per cent is one point down from the March report but is one point ahead of the report for a year ago.

Hospital construction during the period from April 8 to May 19 was active with 68 new projects reported, representing a total valuation of $12,454,000. This brings the total of new hospital construction reported since the first of the year to $56,185,000, a figure well above the $30,000,000 reported for the comparable period of last year. In fact, this is a larger report for the first five months than has been reported in any previous year since 1934 when the monthly records were begun.

Part of the large increase, of course, is due to the construction of new hospitals at Army camps. Most of these projects, however, were announced several months ago and the construction reported recently includes few of them.

Of the 68 projects reported this month, 19 were for new hospitals or allied institutions to cost $4,667,000. There were 41 additions to existing hospitals, which are to cost $6,879,364. Five are alteration jobs to cost $346,000 and three are new nurses' homes costing $562,000.

HOSPITAL CONSTRUCTION



Commodity Price Comparisons

	April 12	May 17
Genl. Wh. Prices	85.9	88.7
Grain	71.4	74.8
Food	74.4	79.3
Textiles	83.2	87.4
Fuel	88.9	92.3
Bldg. Materials	112.5	111.1
Drugs, Fine Chem.	209.1	210.2

The changes in basic wholesale prices affecting the hospital field are indicated in the table above. As will be noted, the general wholesale price index of the *New York Journal of Commerce* advanced sharply; rapid advances were recorded for the prices of grain, food, textiles and fuel. Building materials dropped slightly in the period. A small advance in the price of drugs and fine chemicals was indicated by the index of the *Oil, Paint and Drug Reporter.* (This index is based on prices as of August 1, 1914, while the others are on average prices of 1927-29.)

The cost of living of wage-earners' families in April was 0.7 per cent above March and 2.2 per cent above April 1940.

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SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Alloys F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Equipment for Small Laundry

Question: What kind of laundry equipment would be most economical in a 25 bed hospital?—M.C.B., Mich.

ANSWER: The linen volume required in a 25 bed hospital can be economically and effectively laundered on the premises. We do our own laundry work to our entire satisfaction in a hospital of only 20 beds. The volume runs as high as 3500 to 4000 pounds per average month.

Our equipment consists of a 40 pound wood washer equipped with a ¾ h.p. motor and with thermometer and water glass to help the operator maintain temperatures and water levels. Wringing is done by an extractor of the regular laundry type with a 20 inch basket driven by a 1½ h.p. motor. The drying is done in a small tumbler heated with gas and driven by a 1/3 h.p. motor. This is used to shake out the material after extraction, to predry for ironing on the small ironer and to dry completely bath towels, blankets, diapers and such other work as is best used unironed.

The tumbler has a capacity of 20 pounds per load but will handle two loads while the washer is handling one. The ironing is done on a small machine with a 48 inch roll with two open ends. It is automatically controlled so that we can iron uniforms partially; we finish them with the hand iron. The ironer also takes care of the sheets, folded once, and pillow slips and other material, singly. It is heated with gas and is driven by a ¼ h.p. motor.

We are convinced that a laundry is just as valuable in our small hospital as it would be in an institution many times the size. By operating our laundry with gas and our sterilizers with electricity, we eliminate the expense and care of a high pressure steam boiler. — MABEL WILKE.

Cases for Staff Discussion

Question: Ours is a small eye, ear, nose and throat hospital. Often at the monthly staff meeting various men are asked to present interesting cases which they themselves select. Can the medical records committee, after reviewing the patients' charts, request a doctor to discuss certain of his private cases and is it that committee's duty to specify which cases shall be discussed?—H.L.S., N.Y.

ANSWER: The economic status of the patient should not be a factor in the selection of cases for discussion at staff conferences. Generally speaking, the argument would be stronger for the inclusion of the private patient in these discussions, rather than the charity patient, because consultation is usually more freely available to the charity patient. He is not supposed to pay for it; the private patient is.

The medical records committee should have the authority under the by-laws to require any physician privileged to practice in the hospital to discuss any case it selects for discussion at the monthly staff conference without regard to the patient's economic status.—GRAHAM L. DAVIS.

Medical Records

Question: How long should hospital patients' records be kept?—E.B.B., New York.

ANSWER: According to the recommendations of the American Hospital Association, the American College of Surgeons and the American Medical Association, medical records should be kept on file indefinitely.—MRS. EDNA HUFFMAN.

To Collect Commercial Insurance

Question: What should the hospital do when a commercial group hospital insurance company pays the patient but the patient fails to pay the hospital?—A.L., Mo.

ANSWER: The fact that a patient has purchased a commercial hospital insurance policy in no way alters the relationship between him and the hospital. The patient is still liable for payment of the hospital bill; his insurance policy simply protects him.

Under approved nonprofit hospital service plans, hospitals are paid directly by the corporation upon submission of the bill. Under commercial insurance policies, payment is made to the patient unless the patient, upon admission to the hospital, specifically authorizes the insurance company to pay funds due him to the hospital. Certain insurance companies are now providing policyholders with assignment forms.

Such authorization by the patient, however, sometimes precedes acceptance of liability on the part of the insurance company and hospitals should be advised to obtain written acceptance of liability from the insurance company before accepting such assignment as payment for any part of the hospital bill. Just because the subscriber assigns his interest in a possible payment from the insurance company is no reason for assuming liability of the company.

In the event that such assignment has not been made and payment after being made to the patient is not, in turn, made to the hospital, the hospital has the same collection problem it would have had if the patient were without insurance covering his hospital bill. Attention of hospitals should be drawn to the difference between patients protected by commercial insurance company policies and nonprofit hospital service plan agreements in this respect particularly.—E. A. VAN STEENWYK.

Staff Selection

Question: What can be done to restrain the activities of one man, an osteopath, in the hospital (maternity)?—R.R.A., Colo.

ANSWER: The governing board of the hospital has the right to select its staff. This has been established by numerous courts commencing with a decision in 1918. All hospitals should adhere to the principle of extending privileges only to graduates of medicine with an M.D. degree from approved medical schools. It is incumbent upon the governing board to say that such a principle shall be adhered to in extending hospital privileges or in appointing the medical staff. The whole matter of control is in the hands of the administration of the hospital. That is universal custom with supreme court decisions to back it.—MALCOLM T. MACEACHERN, M.D.

Operating Room Schedules

Question: When staff members ask that the prearranged schedule for the surgery or the x-ray department be upset to accommodate new cases, how is this arranged?—A.L., Mo.

ANSWER: A clear understanding and consistent interpretation of the rules covering the assignment of time for use of the operating room or x-ray department will prevent frequent requests for exceptions. The occasional request based upon unusual circumstances, which should be limited to those of emergency character, can usually be arranged. The doctor making the request realizes that he must have a good reason for seeking an exception and the doctor who is to be inconvenienced appreciates that there is an adequate reason for his being inconvenienced. When the medical staff realizes that operations will start as scheduled, they themselves become important factors in assuring success.—WILLIAM J. DONNELLY.

LOOKING FORWARD

Fireworks Hazards

LAST year there were 4462 injuries of all kinds as a result of Fourth of July fireworks. Excluding the Southern States, which do not celebrate the holiday extensively with fireworks, "there are few exceptions to the rule that only those states that have enacted and enforced state-wide laws have shown evidence of satisfactory control," according to the *Journal of the American Medical Association*. "The injuries and deaths still resulting from this unnecessary cause clearly illustrate the need for additional legislation and consistent enforcement."

Hospitals are in an excellent position to call public attention to the fireworks hazard and to join with other professional and community agencies to control this danger to health and, specifically, to eyesight.

Buying in an Emergency

THIS is a difficult period, indeed, for those who purchase for hospitals. Government priorities, aid to Britain, limitation or elimination of certain imports, advancing labor costs and other factors are affecting the price and availability of many hospital supplies.

It is important that hospital trustees consider carefully the whole matter of purchasing policy for each institution. Should the hospital buy only at the regular volume? Should a three months' or a twelve months' quantity of supplies be laid in now? Should the hospital assume that all supplies are going to advance drastically in price and purchase enough nonperishable items to last for two or three years?

Recently, the chairman of the public relations committee of the Hospital Industries Association discussed this matter before the Midwest Hospital Association. His advice merits careful study by all hospital administrators and trustees.

In the first place, this representative of industry acknowledged that the priorities that have been established on aluminum and certain other metals will make it more difficult to obtain immediate deliveries of certain products. Also, real hospital needs may be increased somewhat, especially in the case of those institutions located near rapidly growing defense industries or those making serious preparations for disaster and defense emergencies. Whatever additional purchasing is necessitated by these factors is entirely legitimate and should be done as expeditiously as possible.

But if all hospitals in the United States become panicky and begin to purchase large stores of instruments, linens, blankets, foods and similar items, prices will shoot up rapidly and unnecessarily. Hoarding on the part of any large group of consumers (and hospitals are large consumers by anybody's yardstick) can result only in harm to everybody concerned. It might force the federal government to extend price controls and priorities.

Heavy advance buying is gambling with the public's money. If hospital administrators are so well informed that they can predict the future of price movements in this country accurately, they are smarter than most business men. The retail stores of Philadelphia, for example, have increased their inventories only 7 per cent during the past year. Yet retail merchants devote their lives to studying the probable price fluctuations.

During the decade just past we had a buyer's market. Sellers used all of their ability to get us to buy. Today the situation is reversed. The hospital supply houses have many orders that they cannot fill immediately. In deciding whose order is to get priority, the manufacturers and dealers will undoubtedly be influenced, to a certain extent at least, by the records of the various hospitals. Those institutions that have good records for honesty and fair dealing will reap a just reward.

Now is an excellent time for hospitals to forge even stronger those bonds of trust and confidence that mark the relations between the best hospitals and their suppliers. Do not order the same goods from two different houses and then cancel the second order when the first is received. Do not say that you must have delivery in a week if actually you don't need the goods for four weeks. Tell the salesman the true situation so that his house can make an intelligent effort to meet the needs of all hospitals. Plan your needs as far in advance as possible and attempt to place your orders well before expected delivery so that the supplier can plan his work most economically.

We are fortunate that the hospital supply industry today is far better organized than it was during the World War. With honesty, reasonable foresight and proper self-restraint, the needs of all hospitals will surely be met without serious hardship to any.

Free Radium Treatments

AN INNOVATION in hospital service is the provision of free radium treatments by Jewish Hospital of St. Louis.

Under the new plan, which is to be tried experimentally for one year, the loss of income from radium is expected to be balanced in the hospital's budget by the receipt of room rents and other fees from patients who need the treatments but who have been deterred from taking them by the cost.

Florence King, administrator of the hospital, points out that radium treatments have long been offered free to poor people and also have been available to the small percentage of patients with ample funds. The new policy will make radium treatments possible for a large group of middle-class patients. The hospital has 100 milligrams of radium, valued at about $3500.

This free radium plan is part of a broad program under which the hospital has been striving to make special laboratory tests and treatments available to patients at less cost. Ultimately, it may lead to an inclusive rate system.

Students and Interns Deferred

THE Selective Service System is to be congratulated upon the memoranda sent out on April 22 and May 2 directing the attention of local draft boards to the shortage of physicians and to the urgent need for continuance in training of all medical students and interns who are making acceptable progress.

Because of this new national policy, there should be no serious decrease in the number of physicians available each year. The memoranda point out, however, that the supply of physicians is already less than the demand, owing to the need of the federal services for 9000 more physicians and to the increasing demand for physicians in industrial hygiene.

The memorandum on medical students states that "it is of paramount importance that the supply [of physicians] be not only maintained but encouraged to grow and that no student or intern who gives reasonable promise of becoming an acceptable medical doctor be called to military service before attaining that status." It is suggested that interns be commissioned in the Medical Reserve Corps and, it is stated, that if so commissioned, they will not be called to active duty during the first year of internship. "Consequently, even though a local board places an intern in Class 1A by reason of determining that he can be spared from the community, such intern may, by becoming a member of the Medical Reserve Corps, complete his first year's internship."

While congratulating the Selective Service System on the wisdom of this action, it might not be amiss to point out that the officials concerned should carry their studies further and, if at all possible, make the same kind of regulations concerning hospital residents.

The need for well-trained specialists for Army and civilian service is so important that every effort should be made to keep residents in training, at least until the completion of their third year. From 20 to 30 per cent of the men completing internships each year should be allowed to enter residencies. It might be unfortunate if the only candidates for residencies were those who had been rejected for military service.

Regional Hospital Assemblies

IT HAS been gratifying this spring to observe the fine programs, excellent attendance and high degree of interest manifested in the various regional assemblies. When from three to twelve state associations join in presenting a unified educational program, the quality of the addresses and of the discussion periods is generally improved. By contrast some of the meetings of unaffiliated state associations have been lacking in vitamins.

The principal argument advanced against the regional associations has been fear that the identity of the state hospital association would be lost and its power in legislative matters would disintegrate. The experience of the Michigan Hospital Association should be an adequate answer to those who are fearful. At the recent Tri-State Hospital Assembly in Chicago, the Michigan Hospital Association had more hospital administrators in attendance than had ever attended a meeting of the state association. In addition, there were many trustees and department heads. No one familiar with the work of this association could today accuse it of lack of strength. Yet the members of the Michigan association helped to arrange a program at the Tri-State Assembly that they never could have arranged for their state association alone.

The history of the Association of Western Hospitals, the Southeastern Hospital Assembly, the Midwest Hospital Association, the New England Hospital Assembly and the Carolinas-Virginias Hospital Conference parallels that of the Tri-State. Members and officers of unaffiliated state hospital associations might well ponder the implications of these successes and read again Doctor MacEachern's splendid report on page 81 of the 1940 *A.H.A. Transactions.*

Defense and Hospitals

THE president of the American Hospital Association is rendering an important public service by touring the country preaching the importance of hospital preparedness for emergencies. We are all too prone to put off consideration of unpleasant matters. Let's face this problem now and lay our plans carefully and well while we can lay them without hysteria and confusion. Every reader of The MODERN HOSPITAL will do well to study the symposium on defense, beginning on page 43 of this issue, and to bring it immediately to the attention of his trustees.

Sabotage—An Immediate Hazard

New Haven's Preparedness Plan

JAMES A. HAMILTON

Director, New Haven Hospital, New Haven, Conn.

THE present war emergency spotlights the old problems and challenges us to improve our present handling of those problems. The first step in terms of this war emergency is to ascertain weaknesses within our own hospitals and communities and to proceed to correct them.

We must assume immediately a mental attitude that adjustments, sacrifices and readjustments will have to be made. We can obtain this mental preparedness if we assume that present difficulties cannot be entirely avoided.

We should get our employes together and discuss with them the possibilities of disaster. We should explain that we will not have as many employes as we now have and that they will have additional burdens. In other words, we must promote in them the same attitude of national sacrifice and patriotic interest that we ourselves should have.

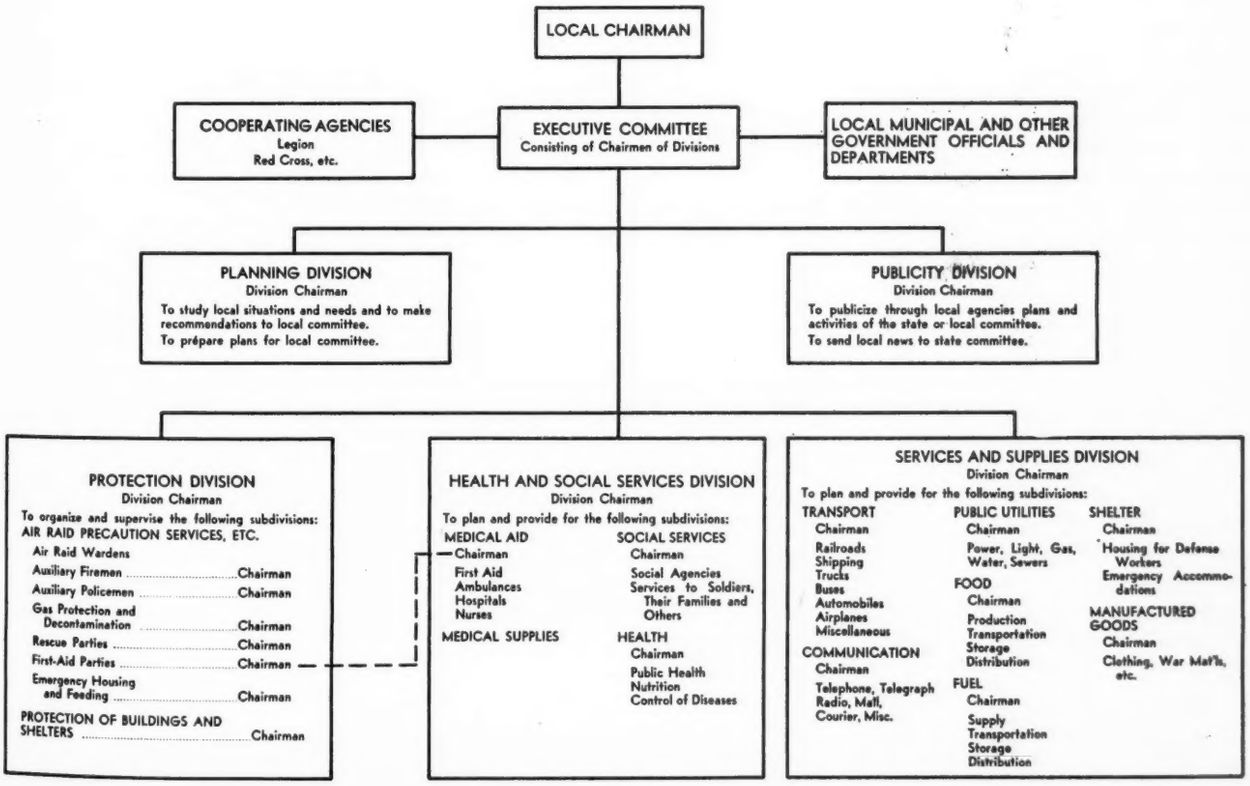
In New Haven we are assuming that we are going to be up against sabotage almost immediately. We have industrial plants that are vital to national defense. We have depositories of powder supplies. We are on the East Coast and the chances are that, if war starts, New England may be an avenue of attack.

A local defense committee has been created in each city or town, working under the general guidance of a state coordinating committee. The local committee's duties do not infringe upon those of the military forces, of police and fire departments or of other regularly constituted government agencies. Its duties are so to plan and organize that civilian defense organizations will be ready to assist and supplement the work of the regular government agencies.

The organization best suited to meet the needs of civilian defense is one which will combine central help and guidance with a large measure of local decentralization and which will also allow sufficient elasticity to meet the varying needs of the communities within the state. Therefore, it is both necessary and advisable that the cities and towns should work out the details of their own organizations with due regard to local conditions. The accompanying plan of organization has served as a general model.

Let me outline briefly the immediate plans that have been made by joint committees of the hospitals, the medical society, the Red Cross and the defense committee in the health division. The public health authorities are recording all the sources of water supply and are making plans for digging wells to be available if the water lines are interrupted. They are working out plans to meet

ORGANIZATION PLAN FOR LOCAL UNITS OF DEFENSE



a major catastropne to the sewage systems. Each of us is planning how we would take care of the electricity requirements provided our supply was interrupted.

For the care of the injured, the city is divided into four zones. The size of each zone was determined primarily by the density of the population, the acreage and the number of industrial plants included. Within each zone there is a complete centrally situated headquarters having the necessary supplies to give first-aid treatment to all ambulatory cases in that zone. There are several minor substations scattered throughout each zone. Each station is mobile in character.

Professional District Officers

At each station there will be a physician and a nurse who act as district officers. The physician lives within that zone and is not vitally necessary for hospital work, *e.g.* school physicians, doctors in private practice and some industrial physicians. Those who might be immediately called for hospital activities are not assigned to these duties. Nurses are also taken from those groups not vitally necessary for the hospitals, namely, the visiting nurses, public health nurses and retired Red Cross nurses. There is a volunteer group of laymen who are assigned to act as stretcher bearers in cases of emergency. This group is supervised by American Legion members.

Transportation vehicles are specifically listed within each zone to provide a sufficient number of trucks and passenger cars to be ready for an emergency. Drivers have been instructed as to their individual responsibilities. The police department is of vital assistance in this phase.

In the event of a catastrophe, a central siren will announce to the community organization in what zone the catastrophe is taking place. Each member of the organization will report immediately to his respective station. The telephone company will assist in locating and notifying members of the organization. These organizations are already set up; the personnel and the exact people with their names and their stations have already been chosen.

If, for example, the Winchester Repeating Arms Company blows up, we might have 300 or 500 injured. The patients will immediately clear through the nearest substation. There they will get serum and will be tagged for identification before they are brought to the hospital. The plan is elastic enough to take care of a catastrophe of that sort and also epidemics, hurricanes or a major fire.

The hospitals are asked to organize only the activities within their institutions. The substations are the responsibility of the medical society. In our three hospitals we are asked to be prepared to provide at least 300 beds in addition to those we now have. Each institution has decided where it is going to put these extra beds. Preferably, they are placed in solariums and in waiting rooms near auxiliary services and not in the central living room of a nurses' home or in a gymnasium. It may be wise to put them across the street in a church that has a very large area or to put them into some other public building. In general, it is desirable to stay away from armories or anything else that would be a military objective.

First, we determined exactly the number of additional beds we could handle. We made a detailed list of all the supplies and equipment necessary to take care of these extra patients for one week. We selected a week upon the thesis that the American Red Cross would make available to us a great many things if they had twenty-four or forty-eight hours' notice. We included all the bedside equipment that is needed, such as pus basins, bedpans and syringes; the municipal government and the Red Cross were asked to supply sufficient funds to buy them now.

For emergency beds we selected an army cot and a supply of these has been purchased by the Red Cross and is actually stored within the hospital walls, along with blankets and dressings, all of which are earmarked for emergency purposes solely. A reserve supply of blood plasma is being created also.

An internal organization is being set up to take care of emergencies. Reception and care of patients are planned to take place in a central reviewing depot staffed with doctors and nurses. The receiving doctor indicates the emergency care that he has given each patient and what is vitally needed. For example, we have a blue tag for those patients who are to go to the operating room, a red tag indicates a blood transfusion case and a white tag designates certain antitoxins. The admitting and the social service departments are to make sure that the patients are identified, to give out the necessary public information and then to contact and to control the public.

The area plan serves to handle the first immediate stage of a catastrophe. We are also cooperating with the other agencies within the state to set up regional groups. Here we are thinking of the second stage: the possibility of bombardment or the possibility of caring for more than 300 extra patients. We have selected various state-operated institutions that have large capacities and low occupancies. For example, construction has just been completed on an institution for the feeble-minded that has 1500 beds available. It is located so that it can be approached from a great many different avenues. This institution will serve a little more than one county. Another institution selected is a veterans' home in another area of the state. Mobile transportation units have been organized in the region with properly equipped ambulances and trucks for the rapid evacuation of patients if this should be necessary.

Hospitals Play Vital Part

Any consideration of wartime conditions emphasizes the vital part that hospitals play in national defense. Health measures to prevent industrial interruption and to promote industrial hygiene and industrial medicine should be encouraged.

Men in the hospital industries these days are concerned entirely about priority. The government has set up priorities for their products. Yet before these priority orders are finished, they are asked to produce something else as a new priority.

The same thing is likely to be true about our defense preparation. We say now that we need not prepare for bombing tomorrow. However, we think there is an immediate hazard of sabotage. Unless we get started and do the first step, we may find that the priorities of defense will pile up on each other and we won't be able to prepare ourselves as quickly for the air raids if that or any more pressing emergency should appear immediately in the offing.

Defense Measures the Country Over

Preparedness, in line with the national emergency, is the major topic of discussion where hospital people congregate. Here is what some of them are doing

THE hospitals of New England and the Eastern Seaboard, under the vigorous leadership of the trustees of the New England Hospital Assembly, have been giving more attention to defense preparations than those in any other area in the country, according to data reaching The MODERN HOSPITAL.

Since the American Red Cross and the National Guard, which usually handle major disasters, are now busily engaged in other activities, the hospitals believe that they must be prepared to step into the resulting breech.

On the Pacific Coast, also, there is careful planning for emergencies by some of the more alert administrators.

Throughout the country, hospitals are awakening to the seriousness of the present situation and are giving major attention to it.

The MODERN HOSPITAL has collected considerable information on this subject, some of which will be presented in the present article. Future issues will keep administrators up to date on important developments. The article by a member of our editorial board, James A. Hamilton, which precedes this, should be considered as a part of this report.

From Dr. A. G. Engelbach, secretary of the New England Hospital Assembly, comes the following statement regarding the work of hospitals in that area.

"Here in New England preparations are being made along the following lines:

"1. Surveys of hospitals are being made to find space for additional beds.

"2. In hospitals that are sufficiently wealthy, a certain number of beds have been equipped to take care of anywhere from 10 to 100 additional patients. This equipment includes the bed, the bedside stand, the mattress, pillows, sheets, other linen and all necessary clinical utensils.

"3. Certain hospitals that normally carry limited supplies have laid in extra stores of canned foodstuffs.

"4. As for the clinical materials, such as bedpans, basins and instruments, many hospitals long before the all-out program was announced took inventory of their stock and obtained an adequate supply to take care of their replacements for the next three years.

"5. We have looked at the problem of trained personnel realistically and have realized that it will probably be impossible to take the time to train individuals to the extent to which they have been trained in the past. In some of the smaller hospitals, the more intelligent maids have been assigned the task of giving bed baths, changing linen and caring for the patient with the exception of changing dressings and administering medicine. These items have been left to the care of the graduate nurse. Needless to say, maids, when working in such capacities, must have the intelligence to understand the sickness with which they are dealing. They must also have been taught the possible sources of infection to themselves.

"6. Certain hospitals have made extensive studies of gasproofing for some of their facilities, especially at the telephone board and in the operating rooms. Communication is one of the most important functions and, for this reason, the switchboard was included in this study.

"7. Although I have no knowledge of the actual construction of bombproof shelters for personnel and patients, consideration has been given to possible means of bombproofing present structures. The lessons learned in England have been thoroughly studied. The possibility of using lower levels and of digging in or under such buildings to a greater depth has been considered.

"8. Certain administrators have listed those classes of patients that could be moved from the hospital to make room for more seriously injured patients. While convalescence in the hospital relieves the pressure on the individual and the home, yet it is not necessary for an appendectomy patient to remain at the hospital for from twelve to fourteen days of postoperative care. After three days' time the convalesence can take place at home with as much ease and comfort as at the hospital itself. Some patients with fractures in proper casts, with chronic heart disease, with nephritis or terminal carcinoma, obstetrical patients and convalescents from pneumonia, all can have convalescent care in their own homes. The removal of such patients will make their beds available for acute accidents. A current survey of the patients who could be moved should always be on hand.

"9. Surveys of neighboring churches, schools and other buildings that could be readily adapted to the care of convalescent patients rather than to the acutely injured have been undertaken and in some cases the possible use of the facilities as an acute hospital has been considered. Such things are not advisable, however because of the necessary plumbing and furniture reconditioning.

"Perhaps the greatest preparedness of all has been the preparation of the mind of the administrator to cope with emergency situations larger in scope than ordinary emergencies. We know that an automobile accident in which four persons are injured causes us great concern for a few moments. To be prepared for a possible bombing of a munitions plant or for sabotage in which an entire factory is blown up with the possible burying and maiming of the employes or for a bomb dropping on a school or church with its attendant injuries to individuals is, I believe, one of the greatest forward steps in preparation for emergency measures throughout the New England area."

Turning now to the Pacific Coast, we find several important developments. According to information provided by Dr. Anthony J. J. Rourke, physician superintendent of

Stanford University Hospitals, the institutions on the West Coast are trying to prevent hysterical buying that will reduce available supplies and tend to increase prices unnecessarily.

"One specific problem that we have to face at the present time is the matter of transportation to the West Coast. A great many articles manufactured in the East ordinarily delivered to us within two or three weeks now are taking six or more weeks for delivery. Apparently, freight and express shipments are becoming so heavy that there is an increased delay in transportation."

Conserve Residents' Time

Doctor Rourke points out that hospitals will soon be faced with a shortage of resident physicians and suggests that every effort be made to conserve their time for the essential duties.

"We can not longer allow house doctors to waste time waiting for records, waiting for equipment, waiting for nursing assistance, waiting in the out-patient department for the wheels to start or spending hours with apprehensive relatives. We must lend the resident every assistance possible so that his entire time may be concentrated in the actual medical care of his patients.

"Every now and then the shortage of some insignificant piece of equipment is brought to the administrator's attention. When it is pointed out the delay and annoyance it causes, he is amazed. If we are going to operate our hospitals with fewer hands, we must ferret out all inadequacies in equipment as well as places at which better distribution of equipment is indicated."

A committee representing the hospital and nursing associations in California has outlined a refresher course of from six weeks to four months for graduate nurses. This outline covers admission requirements, conditions of the course, lists of classes, demonstrations and ward conferences with essential procedures, recommended procedures and some topics for additional instruction if possible.

Dr. Benjamin W. Black, president of the American Hospital Association, has presented the problem of preparedness to various hospital conventions. His address on this subject was reported in the May issue of The Modern Hospital. In addition, he writes that hospitals in the West are doing one or more of the following things (in addition to those previously mentioned):

1. Arranging for the purchase of needed equipment to meet any emergency situation but, particularly, to fill out needed equipment that might not otherwise be purchased.
2. Keeping nonperishable staple foods on hand sufficient for a six months' supply.
3. Giving attention to emergency lighting facilities.
4. Studying methods of complying with black-out regulations, which is difficult because of the large number of windows in hospitals.
5. Studying the water supply to determine methods to follow if the supply was damaged or contaminated.
6. Arranging actual assignment of medical, technical and nonprofessional personnel to duties in event of an emergency and planning for necessary expansion of facilities. This applies even to the acquisition of near-by vacant land for tents or temporary structures.
7. Stimulating further instruction in first aid.
8. Giving more attention to unidentified visitors in hospitals and prowlers who have no business around the institution. In one hospital certain exits have been closed and methods arranged for identifying persons who might be in the hospital to cause damage. It would be easy in most hospitals for persons intent upon mischief to produce a panic.
9. Protecting, especially, the telephone equipment and operators.

The East Prepares

Returning to the East, in Paterson, N. J., both St. Joseph's Hospital and Paterson General Hospital have worked out careful plans for emergencies. The former has a plan sufficient to care for 200 additional patients. The latter could accommodate 57 additional patients on wards, solariums and visitors' sitting rooms and 127 additional patients in libraries, reception rooms and similar places. Lists have been made out to show what sections should be used first. Cots have been purchased and stored in convenient places.

All employes that will be needed in an emergency have been listed and specific persons assigned to each job with understudies to take their places if they are unavailable. Sufficient equipment to take care of the allotted number of emergency patients has been purchased and stored ready for use. Arrangements have been made with the police and fire departments to control visitors and fire hazards. Specific instructions have been given to the telephone operators regarding the handling of calls and provisions have been made for public information service to give facts regarding patients.

The ambulance drivers and ambulance surgeons are instructed regarding their duties, especially that each ambulance in a major emergency must carry as many injured as possible. Admitting procedures are defined and instructions given that the matter of financial responsibility is to be waived for the time being.

Personnel Shortage Met

In various parts of the country, the shortage of personnel is being met in different ways. In Poughkeepsie, N. Y., Vassar Brothers Hospital offered a refresher course for graduate nurses consisting of 10 lectures, each lasting from 7:30 to 9:00 p.m. The result was such a large enrollment that the classes had to be changed to a larger lecture hall accommodating 135 graduates. In addition, there were 35 nurses who wished to obtain actual practice on the wards. The course was limited to graduates of the Vassar Brothers Hospital and no publicity was sent to the newspapers. Because of its great success, the course may be repeated in the fall.

In the Middle West, Wyandotte General Hospital, Wyandotte, Mich., reports that a program of instruction for ward helpers, initiated late in 1940, proved highly satisfactory. According to Lois Day Anderson, director of nursing, sixteen young women were selected for the first course, all of them with at least one year of high school education.

In addition to an orientation lecture, the following demonstrations were given: (1) cleaning the bed after the discharge of the patient; (2) cleaning the room after the discharge of the patient; (3) making the closed bed; (4) making the open

(Continued on page 58)

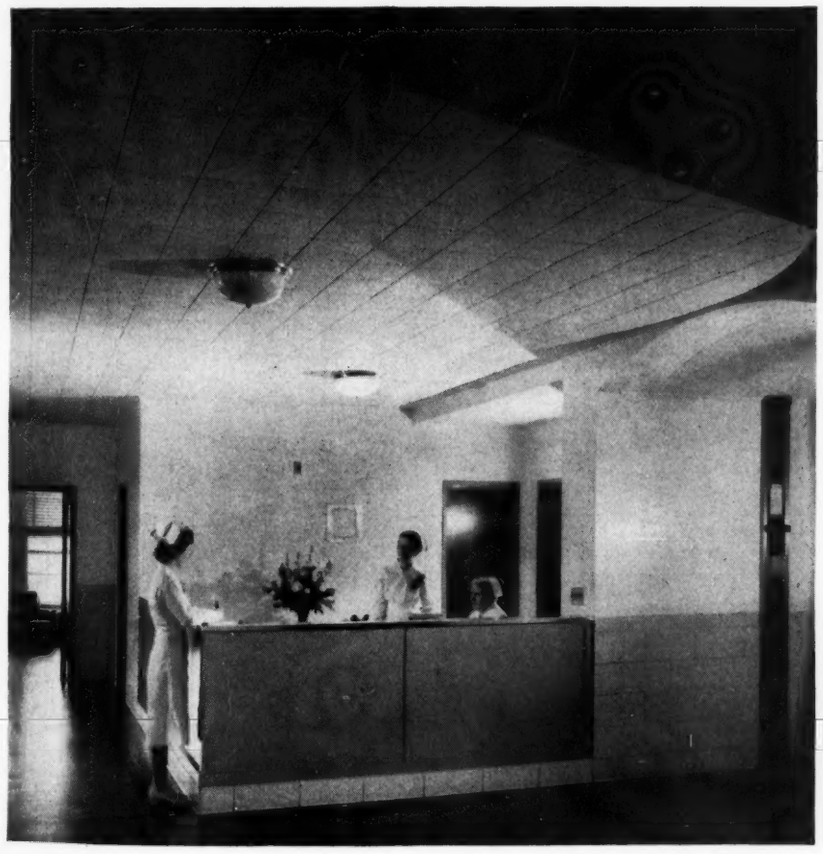
Delaware Hospital Rebuilds

MASSENA & Du PONT
Architects, Wilmington, Del.

C. A. HUME
Business Manager

IN PLANNING the new Delaware Hospital, Wilmington, Del., innumerable problems presented themselves. The new buildings had to be built within the property limits of the old hospital site, which was already covered with scattered buildings, both connected and isolated, all of which had to be kept in operation during the construction of the new project, a period covering two and a half years. Moreover, a new power plant and laundry had to be incorporated in the new building and had to be treated so that sounds from these departments would not penetrate the hospital proper.

Continuous reenforced concrete skeleton frame construction of the slab, beam and girder type was selected after careful preliminary studies indicated that a saving of about $120,000 would be made by its use for the group in comparison with other types of construction of relative comparable fire resistance, rigidity of construction and flexibility of occupancy. In addition to these factors, were those of reduced noise and speed of construction.



Typical nurses' station, which is located centrally in unit 1. Near by are the floor service rooms and the medicine and linen supply rooms.

A requirement was that all patients' beds, private, semiprivate and ward, were to be removed as far as possible from the noise of Washington Street traffic on the east of the property and that, at the same time, the minimum number should face the Wilmington and Brandywine Cemetery on the west. The latter purpose was accomplished by designing unit 2 in an unusual manner.

As will be seen on the plans, some of which are reproduced, the corridor of this unit is off center, which permitted all patients to be placed on the garden side and left the services to face the cemetery. Another stipulation was that the maximum amount of parking space be provided.

The old laundry and power house had to be kept in constant operation until these new services in unit 1 were complete. Therefore, the placing of unit 1 was restricted by the

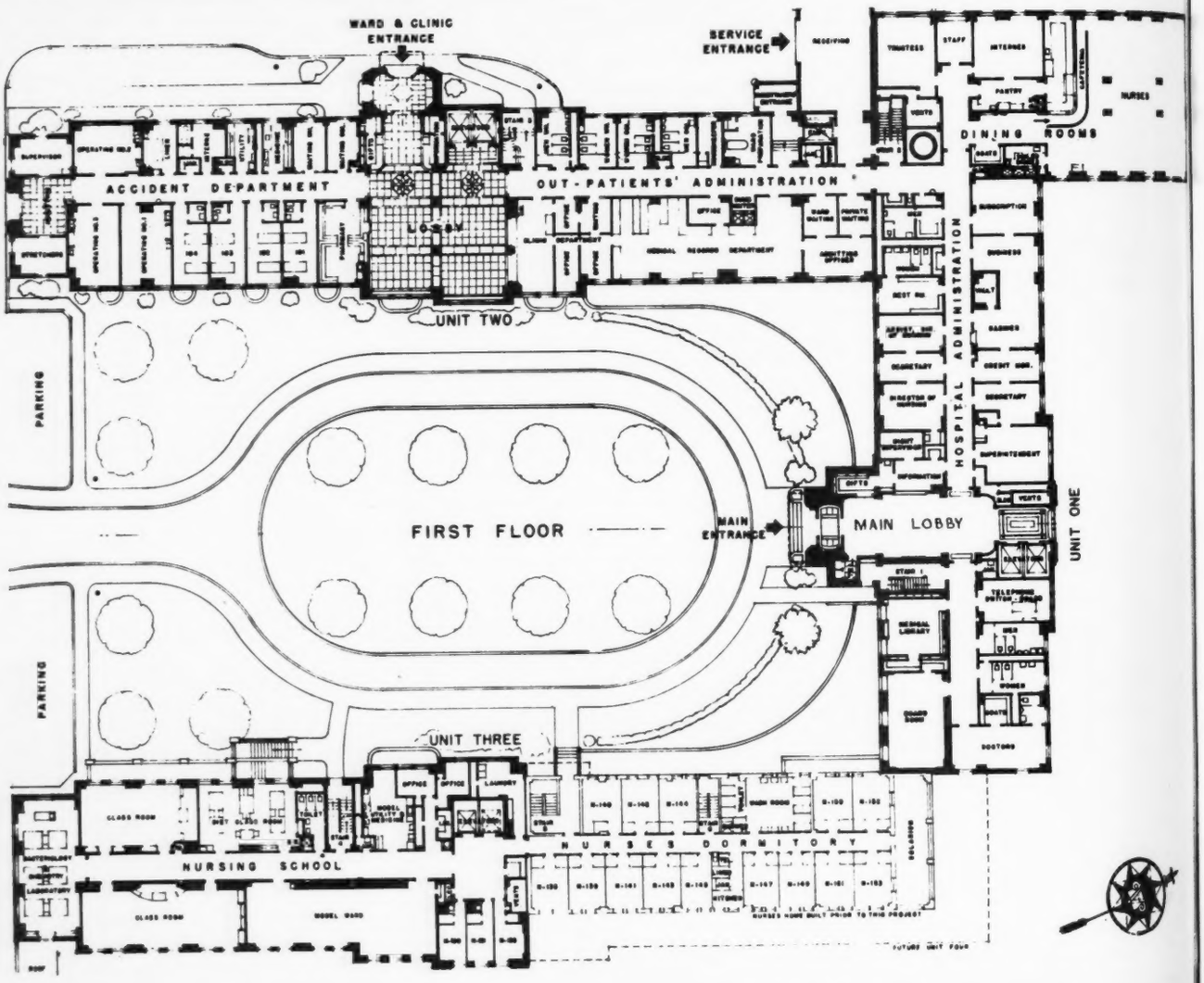
(Continued on page 50)

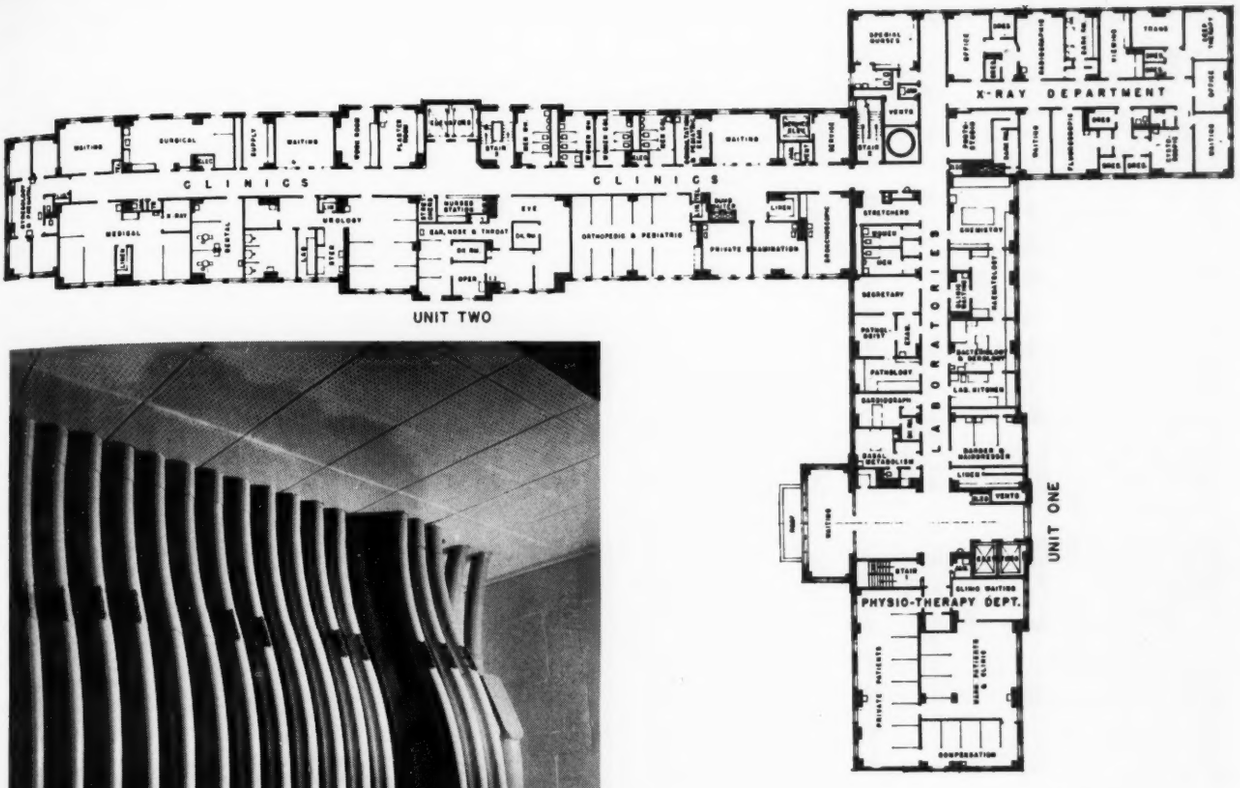
CONSTRUCTION DETAILS

GENERAL DATA: Three separate units. Unit 1 contains boiler plant, incinerator, transformer, vault, laundry, kitchens, staff and help's dining rooms, serving pantries, general offices, laboratories, private and semiprivate rooms, sterilizing rooms, operating room suites, delivery room suites, x-ray suite and electrical treatment suite. Unit 2 contains general stores, various clinics, wards, sterilizing rooms, morgue and necropsy rooms and interns' living quarters. Unit 3 is a self-contained residential school for student nurses and faculty. Facilities have been designed to accommodate 344 patients, but services are so arranged that capacity may be expanded readily to care for 700 patients.

HEATING: Boiler plant, three 500 h.p. high pressure boilers, automatically fired with fuel oil, together with oil pumps, feed water heater, feed water pumps, continuous blowdown system, manually operated soot blowers, heating vacuum pumps and condensate pumps. A large portion of heat normally lost through continuous blowdown reclaimed by heat exchanger through which the blowdown water and feed water pass.

VENTILATION: Laundry, kitchen and dining rooms, supply and exhaust ventilation with remotely located exhaust fans to control spread of odors. Floor serving pantries, laboratories, toilets, sterilizing rooms, clinics and wards, central exhaust fans and distributing ductwork.





Opposite Page, top: Corner of interns' library. Opposite Page, bottom: First floor layout. Above: Second floor plan, unit 3 omitted. Left: Pneumatic tube central station. Below: View of new laundry.

AIR CONDITIONING: Operating suite, fully air conditioned by central refrigeration plant consisting of 40 ton compressor unit, automatically controlled, evaporative condenser, water cooler and chilled water circulating pumps. Remote unit air conditioner for each operating room, with automatic controls.

PLUMBING: Water, waste, gas and fire line service throughout the building. Separate system of acid-resisting waste piping from laboratories to a neutralizing tank before discharge to city sewer. Central water heating and storage system delivers high temperature water to kitchen and laundry and recirculated hot water throughout the rest of the building.

LIGHTING: Two separate primary services arranged with manual transfer, supplying two sets of light and power transformers, one x-ray transformer and one spare transformer that may be inserted in any bank as the need requires. Emergency battery for stairs, exits, corridors and operating suite.

LAUNDRY: Semiautomatically operating washing and rinsing machines accommodating three loads per hour; centrifugal extractors; flat work ironers and clothes presses.

KITCHEN: Belt conveyor system from serving counters to floor serving pantries with push button control station in kitchen. Soiled dishes automatically returned to dishwashing room.

CALL SYSTEMS: Direct intercommunication system. Lamp annunciators in corridors. Doctors' in-and-out register system with two points of registering and lamp indicating board in telephone room.

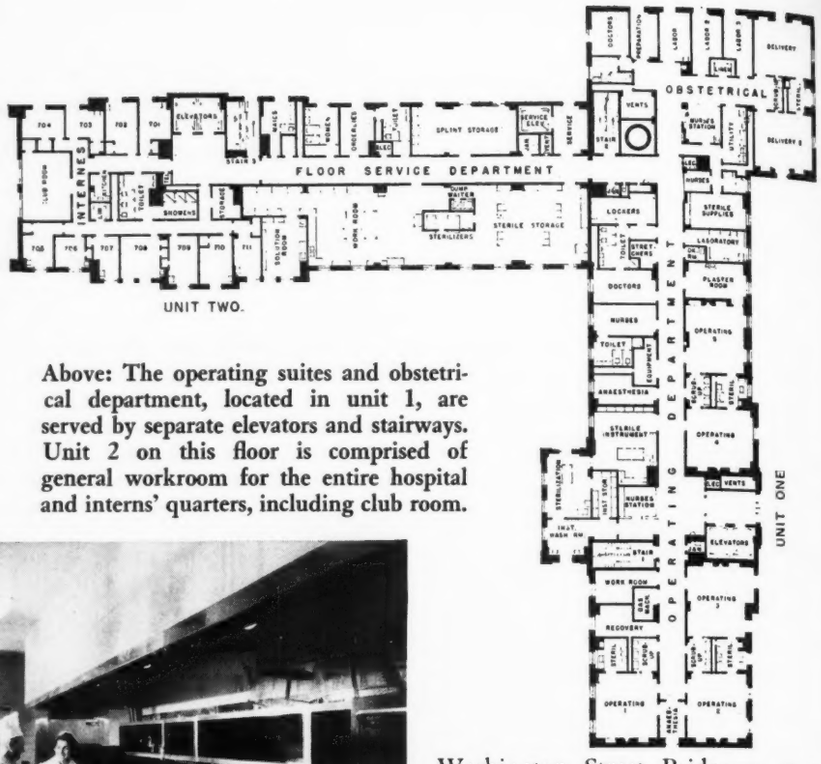
ELEVATORS AND DUMB-WAITERS: Passenger and freight elevators, push button, fully automatic; attendant or passenger operated.

COSTS: Unit 1: $1,739,815; Unit 2: $1,000,000; Unit 3: $700,000.

(Continued from page 47)

location of these two old buildings on the property. The same condition was true of the nurses' dining room, storage rooms and work space. Such units as the old operating rooms, accident department and nurses' classrooms governed the procedure followed in the demolition and construction work of unit 2.

Unit 3 is located where the former private quarters, operating rooms and administration building were; this unit, therefore, could not be started until unit 1 was functioning; also the existing portion of the nurses' home, which is to remain for the time being, had to be kept in constant operation. This old building had to be underpinned at the south end and connections made at each floor.



Above: The operating suites and obstetrical department, located in unit 1, are served by separate elevators and stairways. Unit 2 on this floor is comprised of general workroom for the entire hospital and interns' quarters, including club room.

The other governing factors were those involving circulation of traffic, the number of beds—private, semiprivate and ward—requested by the building committee and all other factors that control any normal building project.

It will be seen that the bank of elevators serving the private wing is located at a central point in this wing in order to provide for a minimum walking distance on any given floor. The same condition holds in the ward wing, designated as unit 2. At the junction of these two units are centered the various service facilities. These include service elevator, food service dumb-waiters, laundry chute, supply lifts and similar services. The same thought has been given to circulation on the various floors by locating at a central point on each the nurses' station, the floor service, and medicine and linen rooms.

The building itself is contemporary in design and bright cheerful colors have been used throughout, while considerable attention has been given to keeping the whole building light and airy.

The architectural treatment of the exterior is one of clean-cut forms, with the emphasis placed on the vertical lines and the various entrances. The monotony of a large expanse of unbroken walls has been avoided by the use of what is known as "flowing color," that is, various shades of brick, which are blended in a continuous change from pink buff at the bottom to light orange at the top, with spandrels of very light brick.

The result is most effective on the Brandywine side, as seen from the Washington Street Bridge or at a distance from the opposite bank of the river.

The new portion of the nurses' home (unit 3) has been arranged so that it may readily be converted to a portion of the hospital proper. When built, unit 4 will include additional private and semiprivate rooms as well as increased quarters for student nurses and, on the seventh floor, an extension to the surgical department.

Although the total hospital patient beds number 344 and the service facilities, such as power plant, laundry, kitchens and operating rooms, have been designed accordingly, they have been so arranged that they can readily be expanded to take care of a 700 bed hospital.

If and when such facilities are required, units 3 and 4 will be made part of the hospital (they have been designed accordingly); a new nurses' home will be built on an adjacent site, and an additional bay will be added to the north end of the projecting wing of unit 1. As may be seen from the plans this bay would include the additional space requirements of the boiler room, kitchens, nurses' dining room, x-ray and obstetrical departments. The laundry, as now built, is of sufficient size for the ultimate development but is equipped only to handle the present requirements.

Do We Need More Beds?

CARL A. ERIKSON

Schmidt, Garden & Erikson, Architects, Chicago

THE annual hospital census of the A.M.A. renders a valuable service. Its use should not be distorted by overemphasizing a by-product of the census, the "average number of beds idle throughout the year." That figure has been used to support statements that "there are too many general hospital beds in the United States." The census also stresses a calculation called the "per cent of occupancy," a figure standing at 70.3 per cent for 1940.

These percentages seemingly support another widely made statement that "one out of every three beds in our general hospitals stands idle every day in the year." If this is true, then obviously hospital expansion should be stopped at once. Is it possible that these figures lie, or have they been misinterpreted?

Before any other comments are made, a correction of the A.M.A. arithmetic should be made as pointed out by Graham Davis in the February, 1941, issue of *Hospital Progress*.

According to the *J.A.M.A.*, "the average number of idle beds in general hospitals in 1940 was 137,200." This figure is obtained by subtracting the average daily census during 1940 from the number of beds available on Dec. 31, 1940. But 17,413 beds were added during the year and it is obviously absurd to assume that all of these beds were placed in service at 12:01 a.m. Jan. 1, 1940. Doubtless these beds were added gradually throughout the year and, hence, the average number of beds available in 1940 was 8706 less than the average used in the A.M.A. calculations. Consequently, the average number of vacant beds in general hospitals should be reduced from 137,200 to 128,494, an error of more than 6 per cent in the average number of vacant beds.

With this correction, the percentage of occupancy upon which the A.M.A. compilers lay such stress must also be revised upward from 70.3 per cent to 71.6 per cent for 1940.

Before pursuing this percentage of occupancy further it is well to recognize that it represents the 462,360 beds in general hospitals, but there are 33,932 beds in special hospitals. There are many beds for specialties in general hospitals. Therefore, a more accurate picture of the hospital facilities and of their use would be to group them all together as "acute disease hospitals" to distinguish them from the hospitals for mental disease, tuberculosis and convalescents and from homes. This is done in the accompanying charts.

Perhaps there has been justification for the census' emphasis on the "percentage of occupancy." Presum-

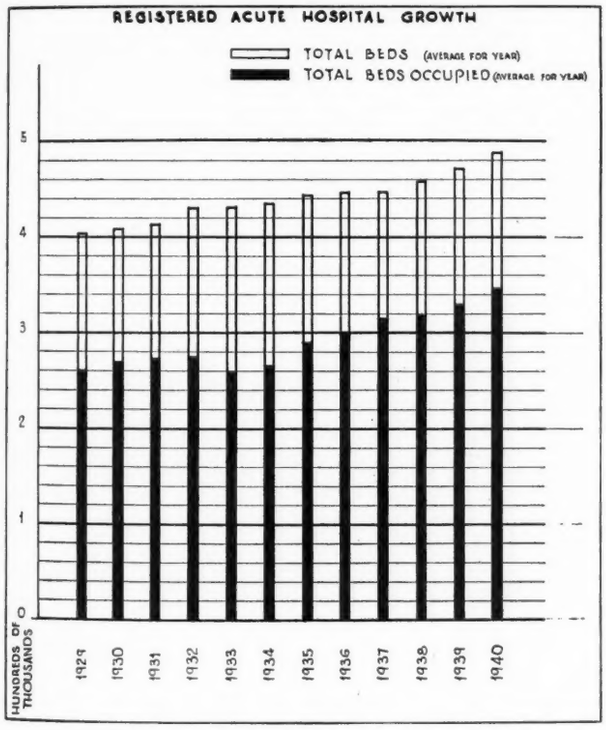


Diagram 1

Although average occupancy in acute disease hospitals increased only 6.4 per cent from 1929 to 1940, actual patient days increased nearly 33 per cent! Figures in charts are based on average number of beds during year. Percentage of occupancy has been recalculated.

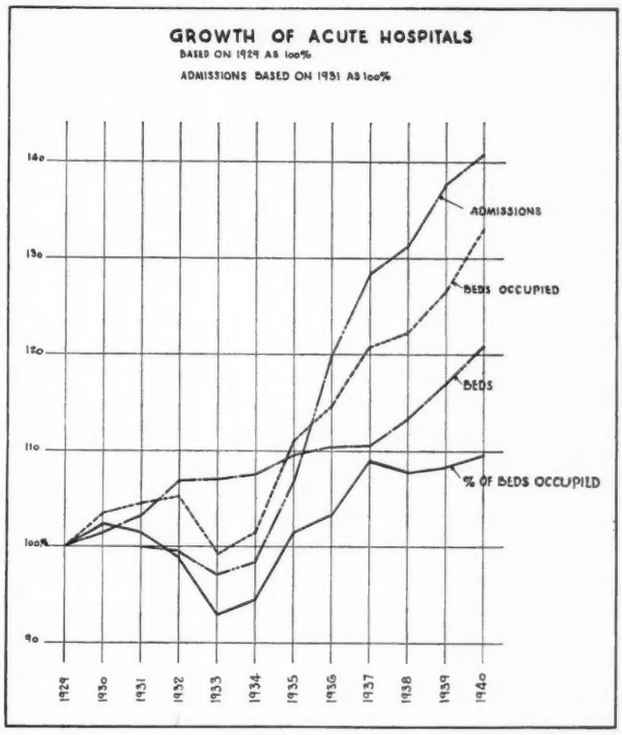


Diagram 2

Percentage of occupancy obviously does not present a true picture of hospital "business," unless considered in conjunction with the growth of bed capacity. The number of beds occupied gives a truer picture of the growth of hospital service during last eleven years.

ably, this "percentage of occupancy" indicates the state of hospital "business" and permits a comparison of this year's business with last year's. Thus, the hospitals might congratulate themselves that last year's business was 6.4 per cent better than in the whoopee days of '29 and 11.9 per cent better than in the wailing days of '33.

Yet a more accurate picture of hospital "business" is that the number of days' care in 1940 was 33 per cent more than in 1929. The reason is obscurely evident from the 1940 census for it shows that while the "percentage of occupancy" in (A.M.A.) general hospitals increased from 69.2 per cent in '39 to 70.3 per cent in '40, yet the average number of idle beds increased by 344.

Hypothetically Speaking

The seeming contradiction of simultaneously increasing percentage of occupancy and of vacant beds is readily explained by hypothetical figures of an imaginary 144 bed hospital. Assume that in 1929 this hospital averaged 80 per cent occupancy for the year and that eleven years later it averaged but 70.3 per cent (the national average), yet its average census in '40 was 2½ times what it had been in '29! The riddle is a simple one. The capacity of the hospital was 50 beds in '29 and it averaged 80 per cent occupancy for the year. Thanks to needed additions, its capacity in 1940 was 144 with average occupancy of 100 patients (70.3 per cent), or 2½ times what it had been in 1929 with 10.8 per cent lower "percentage of occupancy."

Just as in this hypothetical hospital, the average number of beds in acute disease hospitals increased by 84,310 from '29 to '40, or 20.9 per cent, and the average census increased by 85,878, or 33 per cent. Thus the growth in beds did not keep pace with the occupancy. If there had been no increases in the bed capacity and the hospitals existing in 1929 had been able to care for the 1940 numbers, they would have operated at 86.2 per cent of capacity in 1940.

To illustrate what has actually taken place diagram 2 has been prepared. From this it will be seen that yearly comparisons of the "percentage of occupancy" misrepresent the statistical picture of hospital development by apparently showing that there has been only a 4.4 per cent increase in occupancy from '29 to '39 whereas actually there has been an increase of nearly seven times that percentage.

Another correction should but cannot be made in the census. The census compilers must necessarily accept the hospitals' own count of beds. There are hospitals that report beds "that aren't there" and others that, through tragic overcrowding, report beds that are a menace to health standards and decency. As there is no way of estimating the total number of these imaginary, insanitary and overcrowded beds in the A.M.A. census, the fiction that all of the 496,292 acute hospital beds are ready for service in healthful uncrowded quarters will be maintained throughout the rest of this discussion.

The small hospitals, too, affect the occupancy ratios importantly. The small hospital is subject to such great fluctuations in occupancy that Commonwealth Fund's H. J. Southmayd quotes with approval the statement by Dr. W. S. Rankin of the Duke Endowment that they are operating at optimum capacity when their annual average occupancy is but 60 per cent. U. S. Public Health Service Bulletin No. 243 reports that there were 2464 hospitals under 50 beds in 1936 housing 58,747 patients' beds. Those hospitals of less than 25 beds operated at but 45 per cent occupancy; those from 25 to 49 beds, at 51 per cent.

Taking the foregoing information into consideration, it is evident that on an average one out of four hospital beds (not one out of three) stands empty. Is this an appalling waste of philanthropic capital funds, whether taxes or gifts, a terrific indictment of those who have spent about $500,000,000 to provide 96,061 beds that were not needed during the last twelve years?

Before we condemn the hospital trustees and administrators and the public officials who have been spending this colossal sum to increase the number of "average unoccupied beds," it is well to remember that no patient will ever occupy that paper creation, an "average unoccupied bed." The patient at the hospital door must immediately have an unoccupied bed in the sex and clinical classification (and probably the economic group) to which he belongs. Obviously, some beds must be out of service part of the time to permit cleaning, if not for repairs and redecorating.

Some deductions must be made to allow for the statistical procedure followed in practically all hospitals. Statistically, a patient does not exist unless he is in the hospital at 12:01 a.m., 7:01 a.m. or some similar hour when the house count is made; if he is admitted after that he is statistically nonexistent for that day, even though he may have spent twenty-three hours and fifty-nine minutes in the hospital. Thus, there may be at some hour on the days of large influx many more patients than are shown on the daily house count.

Doctors, hospital administrators and patients are accustomed to the week-end or, at least, the Sunday holiday. A study of the daily statistics of one small hospital showed this to account for an average variation between the high and low days of the week of 4 per cent of the occupied beds. Alden Mills' study of three hospitals in the August 1938 issue of The Modern Hospital showed this to average but 2 per cent in three hospitals of over 375 bed capacity. The major holidays, the year ends, the Fourth of July and Labor Day, are instantly reflected in the hospital load, most strikingly evidenced by the week at the year end when it is quite common for the small hospital occupancy to drop 50 per cent. Mills' study showed a drop of 33 per cent on Christmas below the November average occupancy.

Vacations Affect Occupancy

There are times when the use of beds is seriously affected by the vacations of the doctors, an especially important factor in the small hospital but felt in all hospitals to some degree. The empty beds of July or December vanish into the yesterday; they cannot be filled in March except, perhaps, in the minds of those who study statistics.

The need for hospital beds is seasonal; in the North July, August and September are at the bottom of the cycle and February, March and April are at the top.

Thus, one typical midwestern hospital averaged 120.5 patients, or 78.5

per cent occupancy, in its high month and only 90.5 patients, or 59 per cent occupancy, in its low month and attained a yearly average of 107 patients, or 70 per cent occupancy. A study of the daily records showed a peak of 135 patients, or 90 per cent of the capacity, which was a full house to all but those incoming patients that happened to be of the right classification. This hospital, as is the case with practically all hospitals, must be prepared to care for its peak loads, not merely the average of 107 beds.

Just what effect the mass migrations from the South to the North in the summer and the reverse in the winter may have on nation-wide annual averages is difficult to estimate. Many acute disease conditions must be cared for at the place at which the patient is at the time but others can and do await a return to usual residence.

These seasonal variations are piled on top of the probability that the incoming patients will not mesh exactly in sex, age and clinical group. Unfortunately, there are no comprehensive data that would indicate how this would affect the use of hospital beds. If an obstetric patient arrives at a 100 bed hospital operating with 10 vacant beds at that moment, all of them in its contagious and its children's wards, the hospital is full as far as that obstetric patient is concerned. If a male accident patient knocks at the door and finds the only vacant beds are those in the obstetric or gynecologic wards, what good are they to him?

Administrators of two metropolitan hospitals of more than 400 beds, each operating for several years at about 75 per cent occupancy, stated that this percentage was the practical limits of their capacities, that there was undesirable overcrowding in some sections at times and that they frequently had a long waiting list of patients anxious to enter the hospital. A 110 bed hospital in an Indiana town with far less than the usual proportion of beds found it impossible to average more than 79 per cent in spite of long stretches of serious overcrowding in wards, with beds in corridors and porches for considerable periods.

If there are two or more hospitals of equal standing in a community the ebb and flow of patients may be almost identical; if there are 20 hospitals the pattern may be somewhat alike but while the better hospitals may be full to overflowing the others may have empty beds and, hence, the statistics may show the percentage of occupancy for the whole community to be much below that of the better hospitals.

Figures are lacking to enable anyone to study the daily and monthly fluctuations on a state-wide basis. Whether the fluctuations in the population of rural, town and city hospitals follow the same pattern cannot now be determined because of the lack of data. It is obviously a factor that must be considered in determining how many beds a state needs, for the empty beds in Chicago are of little value to the patient knocking at the door of a Peoria hospital.

It is clearly obvious that all of the beds in all hospitals cannot be filled all of the time. It is equally obvious that there are insufficient data to enable anyone to determine the practical maximum of the nation. Taking into consideration the foregoing factors, a reasonable conclusion would be that the hospitals of the nation cannot be expected to average annually as many as 75 occupied beds out of every 100 available without breaking down the minimum standards that have been established by the medical profession as necessary safeguards in the congregate care of the sick.

If the practical limits of the nation's hospitals are 75 per cent, then, since they recorded a 71.6 per cent occupancy in 1940, the hospitals in the United States operated at 95.5 per cent of their practical limits. Our hospitals, therefore, are now operating at capacity or more and they probably have been for the last two years.

In attempting to interpret the A.M.A. census, I do not wish to disparage it in any way. It is unquestionably of great value and our only source of dependable data.

Meet the Hospital Hostess

ROBERT E. NEFF

THE impressions of society regarding hospitals are on the whole quite favorable. We take pride in the fact that the hospital is an institution of mercy where kindness, sympathy, patience and gentleness must prevail.

A hostess or other person on the staff whose particular duty is to attend to the personal welfare of patients, visitors and others who frequent the hospital will do much to give the hospital distinctive character and personality. Numerous tasks may be assigned to this individual which, if performed with courtesy, cheer and sincerity, can create extraordinary appreciation and commendation on the part of patients, relatives and other hospital clientele. Personal charm, alertness and an attitude of accommodation are essential qualities for an outstanding hostess, who can become one of the most indispensable persons on the hospital staff.

The duties of the hostess may be quite varied and will depend a great deal upon the size of the hospital. In small hospitals she may handle admissions and some administrative procedures along with other duties, but in large hospitals her activities must necessarily be more restricted if she is to serve the purposes that her title implies.

Occupying a desk near the main entrance, the hostess will be the first hospital person to be encountered by the incoming patient. She will be approached for information regarding all activites of the hospital, with which she should be familiar. She may serve as a guide to show visitors about the institution and may assist in orienting patients and visitors.

An essential service that can be performed by the hospital hostess is the personal contact with troubled relatives and friends of patients. In this connection, all reports of serious conditions should be made immediately and routinely available to the hostess. Kindly and sympathetic service to the relatives by assisting with telephone and telegraph communications and other necessary arrangements will give the hospital the personality and character for which it stands. Upon the death of patients the same service should be performed routinely.

To Protect Mental Patients

Plant and Personnel Requirements

JACK R. EWALT, M.D.

Resident Psychiatrist, Colorado Psychopathic Hospital, Denver

THE care of most individuals suffering from mental disorders requires little equipment not found in any completely modern hospital. A few patients present symptoms that make it likely that they may attempt suicide or homicide. A few added safety features in the management of the ward greatly reduce the possibility of these tragedies occurring.

The following paragraphs will set forth a few items that will increase the safe operation of the section for the care of disturbed or depressed patients in any hospital that accepts all types of psychiatric cases. These safety features must minimize the opportunity for the patient to injure himself either accidentally or with suicidal intent and must offer adequate protection from homicidal individuals to the other patients and the ward personnel.

These safety features should be included in the original plans of both the physical plant and the personnel department if disturbed patients and psychiatric emergencies are to be accepted for treatment.

Special Construction Features

The section of the hospital devoted to the care of disturbed psychotics should include a few special features of construction. Plumbing, heating and lighting fixtures should be fully enclosed or recessed to prevent depressed patients from burning themselves or from tearing away pieces of metal to be used as weapons for assault or self-destruction.

All glass in windows, doors, light fixtures and wall decorations should be of the shatterproof variety. This will not entirely prevent breakage but will prevent patients from obtaining jagged bits of glass with which they may mutilate or kill themselves. The initial cost of such glass is a considerable item, but in the course of time the money saved on replacement of broken windows and the extra protection for the patient more than justify the expense. The windows should be of the small pane, steel casement type and adjusted to open not more than 6 inches or they should be screened with the new type of detention screens. This prevents the patients from escaping or from jumping from the upper stories with suicidal intent.

Floors should be waterproofed and easily cleaned. The use of either asphalt tile or heavy linoleum makes a most satisfactory covering as these materials are easily cleaned, do not soak up excretions and may be used without rugs or other floor covering. Floor coverings of this type have the disadvantage of requiring a wax polish to maintain a satisfactory appearance. This surface is quite slick, and elderly or ataxic patients should be provided with rubber heeled shoes or slippers to minimize the tendency to fall.

Suitable seclusion rooms should be provided for violent patients. These should be soundproofed and air conditioned to protect the patient as well as to prevent his disturbing the other portions of the hospital. The furnishings in such a room[1] should be simple, nonrigid and easily replaced. They should be made of materials that cannot be used as weapons of self-destruction or assault. Doors must be of substantial construction and should be equipped with a lock of good quality.

The floor and walls in a room of this type present a special problem because some patients amuse themselves by picking at the plaster or floor covering. The amount of damage that can be done is amazing. The floor and walls should be of solid concrete covered with tile or terrazzo construction that is solidly welded to the underlying concrete. Air vents should be near the ceiling and out of the patient's reach.

The furniture in this unit, exclusive of the seclusion rooms, should be of substantial construction. In our experience at the Colorado Psychopathic Hospital, furniture made of steel tubing with washable upholstering has proved most satisfactory. This furniture is light, not easily destroyed and is easily cleaned and the upholstery can be replaced when worn or mutilated. It is also more comfortable and attractive than the wicker or wooden furniture often used in wards for the disturbed.

The clothing of disturbed patients must be carefully regulated. Shoes or boots with hard heels make excellent weapons; aggressive patients should be provided with soft soled slippers. Belts, bathrobe cords and suspenders make fine instruments for self-destruction and should not be issued to patients with suicidal tendencies.

Persons who disrobe or destroy their clothing may be provided with stoutly constructed coverall suits that are of light weight, have locked buttons or zippers and are made of a comfortable, washable material that is unusually strong and cannot be torn until weakened by repeated trips to the laundry. Jewelry, razors, scissors, nail files, cosmetic jars and similar accessories should be issued to disturbed or suicidal patients only during the time they are under the surveillance of the nurse or attendant.

Feeding Disturbed Patients

The feeding of disturbed patients presents special problems. This is best accomplished in a central dining room. Dishes of the newer plastic materials are attractive, cheap and offer poor material for throwing or self-mutilation because they are light and the broken edges are not particularly sharp or strong. Table knives and the tines of forks should be dull. The silverware should be counted as the dishes are removed and before the patients leave the dining room as this prevents smuggling of these objects into the ward.

[1] Ebaugh, F. G., and Ewalt, R.: Finding Room for Mental Patients, The Hospital Yearbook. 1941.

The facilities for continuous tubs and wet packs should be great enough to assure each patient in the section from four to six hours of hydrotherapy daily. The same equipment may be used for patients on the convalescent sections, thus avoiding the duplication of this costly equipment.

Tobacco and matches should be kept by the nurse on the disturbed wards. Patients should smoke only under supervision to prevent their starting fires or burning themselves when confused or with suicidal intent. The supervision of smoking can be handled most conveniently if the patients are allowed to smoke at the same time in the lounge room at certain scheduled hours, at which time tobacco may be issued and cigarets lighted by the attendants and nurses in charge. Bed patients may smoke if some responsible person is present to prevent careless or intentional ignition of the bed clothing.

The inclusion of these features or satisfactory substitutes in the physical plant will greatly facilitate the care of disturbed patients, dramatically reduce the number of "accidents" and free the ward personnel from many arduous tasks of supervision for the more important work of occupational therapy and other ward activities. These features are necessary only in those hospitals that accept all classes of psychotic patients and only in the disturbed sections of such hospitals. The general run of psychiatric patients can be cared for in almost any hospital ward if satisfactory personnel is available.

The most important factor in the safe, efficient operation of any psychiatric unit is the sufficiency and efficiency of the personnel. This applies to the nurses, attendants and maids, as well as to the medical staff. The requirements in terms of numbers and training have been discussed in detail by Ebaugh.[2]

At the Colorado Psychopathic Hospital we employ 32 graduate nurses, 15 male attendants, 7 maids and 4 janitors per 78 bed unit. In addition, we employ three especially trained nurse technicians who do nothing but administer artificial fever therapy. The student and affiliate nurses vary in number but all of their work is closely supervised and they do not lighten the case load of the graduate nurses.

This number is somewhat above the average but we find that the increased efficiency of operation and the decreased accident rate justify the added expense for ward help. For example, in sixteen years of operation the Colorado Psychopathic Hospital has admitted 12,640 psychotic patients of all types and varieties. Seventy-four per cent of these patients have returned home, 21 per cent have been transferred to the state hospital and 4 per cent have died. In this number there have been only three suicides, and one of these was a patient who had been allowed to leave the hospital unaccompanied.

Patients who show self-destructive tendencies should have their attention diverted and their interest stimulated in constructive endeavor. Outdoor walks, music, reading or simple

[2]Ebaugh, F. G.: The Care of the Psychiatric Patient in General Hospital, American Hospital Association, Chicago. 1940.

In the dining room of Colorado Psychopathic Hospital, shown above, patients are grouped according to personal preference. At right is a view of one of the tub rooms. Canvas hooded tubs (A) allow disturbed patients freedom of movement under treatment; water temperature is controlled and recorded automatically by the control box (B). Recessed lights (C) are used throughout the disturbed section of the hospital.

card games make it possible for the skilled nurse to be with the patient constantly. This offers opportunity for directing the patient's conversation and thinking away from suicidal ruminations. The same procedure works well with persons who strive to mutilate themselves. As a further safeguard, each patient's activity is personally observed and noted in the chart each fifteen minutes, twenty-four hours a day, by one of the supervising nurses on the ward.

Not only has adequate supervision by a trained and skillful nurse a powerful therapeutic effect but patients under such a regime rarely even attempt a self-destructive act. While this paper is primarily concerned with the safety of the patient during his treatment, it is of course obvious that an active program in therapy must accompany the administrative routines mentioned.

An occasional patient will be aggressive, combative and uncooperative; some are actively homicidal. This group of patients requires great skill in handling if the hospital personnel and other patients are to be protected and if the patient is to be properly treated at the same time.

The simplest and least effective method is restraint. To be sure, while fastened to a bed by some mechanical device, the patient cannot injure anyone. He will, however, become more disturbed and when released will be more hostile and difficult to manage than before. Most patients regard restraint as a form of punishment and nothing effective in the way of therapy can be accomplished by this method.

Some modified restraint methods combine beneficial treatment with some curtailment of the patient's activity. The cold wet pack and the neutral tub are excellent examples of these. Both are widely accepted and efficient types of hydrotherapy and after such treatment the patient is usually less active and more cooperative. Properly constructed tubs and properly applied packs restrain the patient to some extent.

Persons who are very combative and uncooperative may be placed in either a tub or a pack that holds them securely until the sedative effect of the hydrotherapy curtails the episode. Patients who are merely overactive and annoying to the other patients may be placed in a seclusion room similar to those that were previously described. Here they may work on occupational therapy, run about and in many ways give free expression to their stimulated state without harm to themselves or to others.

In using these repressive measures the ward personnel must exercise great care and judgment and the measures must be closely supervised by the medical staff. Placing the patient in the hydrotherapy room or even in the seclusion room should be done only after tactful persuasion and explanation. Great patience is necessary to prevent the individual from feeling that the treatment is being forced upon him. Most patients will submit to these treatments if given a few moments to reflect and these moments are well spent in the busiest of hospitals because they breed cooperation and understanding rather than struggles, bruised feelings and torn uniforms.

In rare instances, disturbed patients may have to be forced into the tub, the pack or the seclusion room. In these unusual emergencies, enough help should be at hand to prevent unnecessary struggling. The patient should be taken by the arms and, after the necessity of the treatment has again been explained, he should be taken quietly and quickly to the hydrotherapy room without any display of temper or impatience on the part of the attending personnel. One such experience usually convinces a patient that cooperation is simpler and if patience and tact are exercised on future occasions no further trouble ensues.

No mention has been made of the protection of the public. It is assumed that an individual suffering from mental disorder will be placed in a hospital for treatment and thus society will be shielded from his activities until such time as he is able to return to his former routine.

Recreation Yard for Mental Patients

UNDER a plan for enlarging and improving recreation areas, patients at the Florida State Hospital, Chattahoochee, Fla., live out of doors practically the year round on grounds landscaped and equipped for their comfort and enjoyment.

The services of the institution's construction, horticulture and engineering departments were enlisted to plan and carry out necessary terracing, sodding, planting and construction. Work began first on the yards of the white men's division, where stumps, roots, rocks and gullies presented a problem of creating a safe as well as attractive environment.

The yards connected with the two colored divisions were found to be inadequate and were enlarged to include almost twice as much area as formerly. For the criminally insane, a recreation yard was constructed and enclosed with a stone wall for privacy and safety.

The yards are enclosed by chain link fences, concealed as much as possible by hedges and shrubbery. Nearly 100 additional trees, oak and magnolia, have been transplanted to furnish shade. Summer sheds provide protection from the hot sun or light showers.

Sufficient rest rooms are in all yards and electrically cooled drinking water is supplied in small brick structures built for the purpose. About 250 benches, some stationary and some portable, have been placed about the grounds.

A good day finds about four fifths of the patients spending time not scheduled for meals and occupation in the yards. The remaining one fifth includes newly admitted patients, the physically ill and invalids unable to walk.

Patients pitch horseshoes, play soft ball and other favorite games in the yards. As an additional therapeutic activity, the hospital has developed a large out of doors area in which selected patients are permitted to grow flowers and shrubbery on individual plots. Supervised by the occupational therapist and the horticulturist, this program has the double purpose of treating the patient and beautifying the grounds. Accomplishments are rewarded with prizes at the institution's annual flower show.—J. H. Therrell, M.D., *Florida State Hospital, Chattahoochee, Fla.*

A National Study of Salaries of Medical Record Librarians

ALDEN B. MILLS

THE salaries of medical record librarians vary from less than $50 to more than $200 per month (including the full cash value of maintenance), according to data submitted to The Modern Hospital in its second salary survey. Data on these salaries were collected late in 1940 and early in 1941.

The average salary (including the value of maintenance) is $110 a month for the 665 hospitals submitting data on this point. Since reports were received from 1244 hospitals, the other 579 hospitals probably do not employ medical record librarians. Thus, 53 per cent of the reporting hospitals have medical record librarians on their staffs.

Salaries vary somewhat by regions. The average salary in the East is $114; in the Middle West, $108; in the South, $105; in the Mountain-Pacific area, $124, and in Canada, $83.

Even greater variation is found, however, in the salaries classified by size of hospital. Three hospitals of less than 25 beds reported salaries for medical record librarians, the average salary being $70. Fifty-four hospitals of from 25 to 49 beds reported data and the average in this class was $96. There were 170 reports from hospitals of from 50 to 99 beds and in these the average salary was $104. In the from 100 to 199 bed class, there were 248 replies and an average salary of $109. The from 200 to 299 bed hospitals had 91 reports and these give an average salary of $115.

Moving into the from 300 to 499 bed hospital group we have 54 reporting institutions and an average salary of $123. In the largest hospitals, those of 500 beds or more, 45 reported salaries for medical record librarians; the average salary was $133 per month.

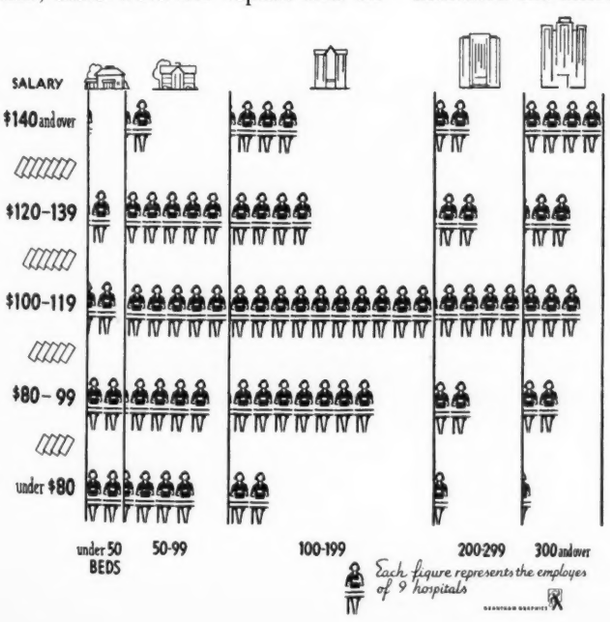
As in the previous tabulations in this series, the value of maintenance was requested from the reporting hospitals. The value set by each hospital was used unless for some reason it appeared to be obviously incorrect. If the hospital did not estimate the value of maintenance but indicated the amount of maintenance provided, arbitrary values were given to each item as follows: meals, $30 per month; room, $10 per month; laundry, $5. For full maintenance this gives a total value of $45 per month.

As will be noted from the table, the highest salaries for hospitals of any given size are paid to record librarians in the Mountain-Pacific States and in the Eastern States. The Middle West and the South pay about the same salaries in hospitals of the same size, with the Middle West slightly higher in most instances. The salaries of the 28 hospitals reporting on this item from Canada are uniformly below those paid by institutions of comparable size in the United States.

Average Monthly Salaries of Medical Record Librarians

	Bed Capacities of Hospitals							
Area	*Under 25*	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Tota*
East	$ 90*	$107	$107	$107	$118	$124	$152	$114
Middle West	55*	91	103	110	106	130	127	108
South	65*	91	97	109	115	125	128	105
Mountain-Pacific		103	118	125	130	140	129	124
Canada		50*	78	85	93**	85	84	83
Total	70	96	104	109	115	123	133	110

*Only one report received. **Only two reports received.

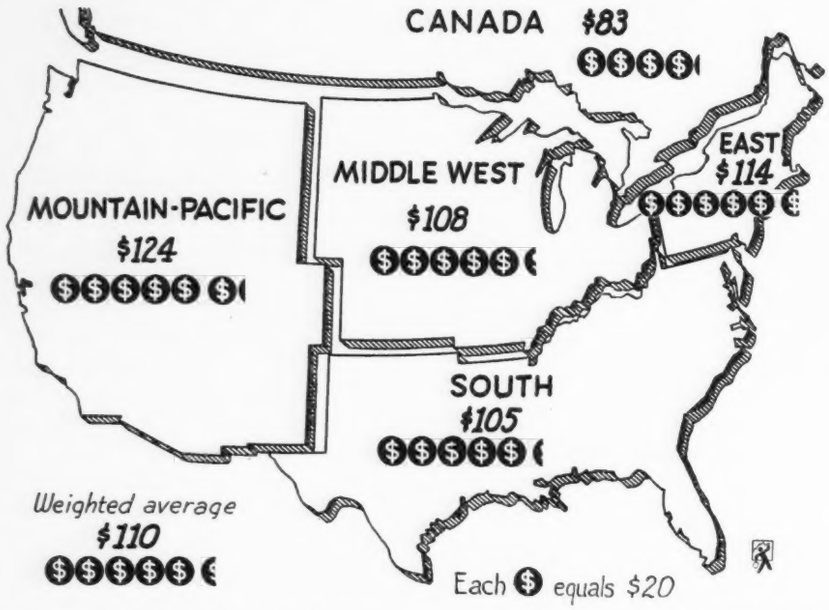


Salaries of medical record librarians, on an average, are lower than those of other hospital department heads.

A competent medical record librarian today is supposed to have had at least two years of college work followed by a course of training of from nine to twelve months in one of the 10 approved schools for medical record librarians.

The abilities expected of a good medical record librarian include stenography and typing, thorough knowledge of medical terminology and of the three accepted medical nomenclatures, principles of filing and record keeping and an ability to prepare and present reports that are of value to the members of the hospital's medical staff.

Certain newer technics being introduced into medical record departments are going to necessitate an expansion of the abilities of the librarian. For example, the photographic



recording of the older records introduces a new piece of equipment into the record room. While most medical record librarians will probably not feel that it is necessary to become skilled in photography, it will be wise for them to have some understanding of its principles if they attempt to use this newer equipment.

Likewise, there is a considerable interest today in the use of punch card methods of tabulation in the medical record departments of the larger hospitals, as well as in other parts of the institution. The technic of coding and punching contains many complications. Most medical record librarians will not find it necessary to master the more detailed technical factors, since the tabulating will undoubtedly be done by central tabulating companies, but some of the librarians will probably wish to explore this interesting field. All of them should have at least a bowing acquaintance with the subject, especially if they are working in large institutions handling thousands of records every year.

From the salaries now being paid to medical record librarians, it is apparent that their services are not yet considered as valuable as those of certain other department heads.

Taking, for example, the hospitals of 50 to 100 beds, in which the medical record librarians receive an average salary of $104 per month, we find the following average salaries paid to other department heads: nurse anesthetists, $130; superintendents of nurses, $158; housekeepers, $84; nursing supervisors, $123; head nurses, $112; pharmacists, $116; dietitians, $124; engineers, $125. Even for floor duty graduate nurses, the average salary is $99, almost as high as for the medical record librarians.

In the hospitals with from 200 to 299 beds, the figures are as follows: medical record librarians, $115; superintendents of nurses, $234; nursing supervisors, $138; head nurses, $123; pharmacists, $150; dietitians, $168; engineers, $198; nurse anesthetists, $151.

Many of these other department heads, of course, are required to have considerably more education and experience than are the medical record librarians. Dietitians, pharmacists and qualified engineers must be college graduates. Many of the nurses in responsible executive positions today either are college graduates or have taken work that is equivalent to that required for a college degree.

A further factor should be considered in making a comparison of salaries within the institution. The medical record librarian in a typical hospital will have a relatively small number of employes to direct as compared, for example, with the superintendent of nurses, the dietitian or the engineer. This, doubtless, is also taken into consideration in the setting and changing of salaries.

An additional fact that receives some weight in certain job analyses is the number of public contacts. While the medical record librarian has important contacts with the medical staff, insurance adjusters and lawyers, she has fewer public contacts than many other hospital employes. The tools and equipment that she has to master, also, are relatively simple.

Another factor may also explain the salaries now being paid to medical record librarians. The profession is young when compared to most of those in the hospital family. There are few medical record librarians who have been in the field for fifteen years.

During the past decade, the profession has grown enormously in number of qualified workers, in importance to hospital organization and in prestige. The registry was not started until 1933, yet now there are more than 1000 registered medical record librarians. Given another twenty years, medical record librarians will probably be commanding salaries in the higher brackets.

Defense Measures Country Over

(Continued from page 46)

or convalescent bed; (5) making the ether bed; (6) making the bed with a patient in it, in cooperation with the nurse in the ward; (7) cleaning the linen room; (8) cleaning the utility room; (9) cleaning the dressing room; (10) caring for flowers; (11) caring for rubber goods and filling of hot water bottles and icecaps; (12) learning facts about personal hygiene and care of uniform.

The ward helpers take much pride in their dark brown uniforms with white collars, cuffs and apron. "These young women are employed on a permanent basis at $49.50 per month. Uniforms and laundering of uniforms are furnished. Hours are on a forty-eight hour basis with either two half days or one full day off each week. Seven days' vacation with pay is granted after one year's service and group hospitalization is available," Miss Anderson states.

At the University of Minnesota Hospitals a course has been opened for the training of W.P.A. hospital and institutional workers. Further details on it will be given later.

Those Fracture Cases

JOSEPH C. DOANE, M.D.

SINCE the advent of the automobile, a large part of the work of a surgical ward consists of the treatment of fractures. A new terminology has arisen to describe some of these injuries. The now well-recognized "bumper fracture" sustained by contact with the bumper of an automobile and the "windshield laceration," or fracture of facial tissues and bones, are good examples. Serious trauma to the bones of the skull with resulting contusion or laceration of brain substance is also frequent.

Every general hospital must have organization and equipment constantly ready to receive and to treat large numbers of casualties promptly and properly. If one lesson has been learned by the hospital field from the conflict now raging in Europe, it is that today the whole nature and scope of institutional war problems have been altered. Now instead of soldiers in the field it is the civilian population, the workers in bombed factories, office buildings and even hospitals, that requires care. Therefore, preparedness by the civilian hospitals of today along the lines to be suggested in this article may represent a highly useful method of meeting possible wartime emergencies.

In the course of thirty minutes, an eastern hospital recently was called upon to admit fifty persons injured in a railroad wreck. If this hospital had not anticipated just such an emergency by previously instructing its personnel and by assembling emergency equipment and supplies, the treatment of these patients could not have been performed efficiently. Preparedness spells orderly, unhurried, yet effective mastery of an emergency. Lack of it means confusion, delay and the aggravation of human suffering.

Modern trends appear to point toward an ever diminishing number of hospitals that own and operate their own ambulances. Indeed, police and municipal authorities in many places are rightfully concerned about the problems of transporting a large number of injured persons in the event of any catastrophe. This trend, therefore, while appearing economically advantageous to the hospital and perhaps to the public presents some real dangers. Perhaps in the future a pooling of ambulance equipment or the adoption of some other plan for emergency transportation may be evolved.

Civilian hospitals should take note of the present all too frequent occurrence of fires and explosions in industrial plants. Any hospital may find its whole facilities suddenly needed to meet just this kind of emergency. Every general hospital should have assembled in a large chest or other container sufficient dressings, splints, instruments and supplies to care for 50 or more accident patients on the shortest notice. Thomas' splints for transporting femur fractures and airplane splints, as well as the most commonly used splints of all types, medications and oxygen should be a part of the equipment.

List No. 1—Contents of Regular Ambulance Bag

Amyl nitrite
Alpha-lobeline
Caffeine sodium benzoate
Digalen, digifolin
Digitan
Ergot
Pituitrin
Alcohol
Adrenalin
Unguentin for burns
Olive oil
Iodine
Distilled water
Methylene blue
Morphine sulfate, gr. 1/6, 1/4
Nitroglycerine, gr. 1/100
Strychnine sulfate, gr. 1/40
Aromatic spirits of ammonia
Calcium gluconate
Lysol
Coramine (ampules)
Atropine sulfate, gr. 1/150
Apomorphine, gr. 1/10

List No. 2—Emergency Box in Quantities to Treat 100 Patients

Adhesive
Adrenalin
Unguentin or similar ointment
Bandage, gauze, muslin
Knife blades
Catgut
Clips
Dressings
Gloves
Medicine droppers
Needles
Padded splints, 2
Tourniquets
Towels

The accompanying condensed list of equipment is divided in two parts: group No. 1 is placed in the regular ambulance bag for everyday use and group No. 2, in larger quantities, should be placed in the emergency dressing box to be used in case of fire, explosion or large traffic accident.

In addition to the foregoing list of equipment, the emergency unit should have available various other types of equipment, such as bed warmers, intravenous outfits and medications and supplies necessary to the treatment of surgical shock, which so often accompanies fractures. In fact this unit should be second in completeness of equipment only to a major operating room.

Whole blood for transfusions must be always available, or prearranged preparations for obtaining it or other blood replacing solutions, such as acacia and blood plasma, must have been made. There is little excuse for a hospital to continue to hope that it will not sometime require blood for an emergency life-saving transfusion and to rely on the assumption that a donor may be obtained promptly when needed. The blood bank is of the greatest use in the emergency treatment of shock because of blood loss or because of the general bodily response to massive injuries of soft tissues or bones.

If a physician and a nurse cannot always be on duty, arrangements should be made so that they can be summoned promptly. They should be well trained to meet the particular type of work.

Prompt diagnosis of the nature and the extent of bone injury is of the highest importance. X-ray examination facilities must be immediately available day and night since the public cannot understand why a patient with a broken bone must wait until 9 o'clock on the following day

before radiologic studies are made. Not every patient coming to the hospital with bone injuries can be x-rayed and treated at once because the general condition of the patient frequently prevents such manipulation. However, the rank and file of fractures of the radius or ulna, the humerus, tibia or fibula, the femur and often the skull may be x-rayed at once with safety. The expense to the hospital of such studies is wholly legitimate and necessary even though the patients are unable to pay.

In some hospitals a system is being evolved whereby the patient is made comfortable and a delayed setting of the fragments is carried out on the following day. In some instances this seems an efficient method. In others, the immediate setting of the bone because of subsequent swelling seems advisable.

The whole scheme of the handling of fractures must represent a well-considered chain of events which begins with the reception of the patient and which ends only after he has passed through the fracture service to the physical therapy department, through the follow-up clinic and eventually is discharged from care. Too often some slip in this chain of events occurs and as a result poor alignment of bone fragments follows. There is no more unfavorable advertisement for the hospital.

Radiographic service is as important in the follow-up care of fractures as it is in their early diagnosis. Many institutions have discovered that the commonly used unipolar fluoroscope is not effective in visualizing fractures during treatment because anterior or posterior dislocation of the fragments may occur when the patient is moved to obtain a view in another plane. The bipolar fluoroscope, which makes possible visualizing a bone in two planes without moving the patient, is highly effective. The location of x-ray equipment near the operating room and the easy access to this department from the accident ward are important structural provisions. Failing this, an efficient portable machine is often found highly satisfactory.

The accident ward should have a small room in which one or more beds are available for the reception of unconscious or shocked fracture patients. To transfer such individuals even the distance intervening between the reception ward and the surgical department may spell the difference between life and death. For twenty-four or more hours such patients may be treated advantageously in this ward under the direction of the visiting surgeon.

The medical student is carefully drilled in the necessity for differentiating between unconsciousness as a result of alcohol and that as a result of skull fracture. This diagnosis having been clinically or radiographically made, the accident ward physician should have clearly in mind the technic required by the neurosurgeon under such circumstances. Incidentally, it may be remarked that in larger hospitals skull fractures are usually placed on the neurosurgical and not the general surgical service.

The following list of instructions relating to the treatment of skull fractures is posted in the accident ward of one hospital.

"Because of the serious possibilities of intracranial pressure in this group, constant observation is necessary. A sudden respiratory failure frequently occurs in cases of brain tumor, hydrocephalus and hemorrhage. The following clinical studies should be rapidly determined:

"1. Temperature, pulse, respiration and blood pressure recorded every fourth hour. If the patient's symptoms are severe, they may have to be taken as frequently as every half hour.

"2. Careful record of all liquid intake and output of urine unless the patient is incontinent.

"3. Careful bedside notes regarding convulsive seizures, twitchings and sudden changes in the patient's condition.

"4. Urinalysis, complete blood count, Wassermann reaction, spinal puncture with manometer and careful pressure readings.

"5. Eye ground examination, Bárány's test and careful neurological examination recorded on the charts, including visual fields and x-ray studies of the skull.

"6. Diet should be solid and comparatively dry to avoid the addition of fluids, which tend to increase intracranial pressure.

"7. Pulse pressure is obtained by subtracting diastolic from systolic, and charts showing T.P.R., blood pressure, pulse pressure, spinal puncture relationships as well as intake and output are combined in a single graphic record."

It is interesting to note a strong trend away from the immediate trephining of the skull in cases in which fracture of the cranial vault has occurred or in which cerebral contusion has been the result of injury. Prominent neurosurgeons in presenting their experiences in the treatment of fracture of the cranial bones repeatedly remark the advantages of more conservative treatment.

This is the first of two articles covering the hospital treatment of fractures and their complications. The next article will describe the institutional fracture cart and other necessary fracture apparatus.

For the Asthmatic Patient

THE season is approaching when the increased demand for the hospitalization of asthmatic patients will create a problem. It is hard to care for a large group of these patients economically. There is on the market, however, a small, compact and efficient air conditioning unit that is installed directly in the window.

Supplementing this air conditioning unit is a filtering unit that cleans not only the air coming from the outside but also that contained in the room. The only connection needed for this apparatus is an ordinary light socket. Temperatures can be regulated and stabilized at around 78° F.

Owing to the comparative inexpensiveness of the installation, a large number of patients can be cared for with a small additional per diem charge for each unit.

It is good practice to condition and filter the air several hours before a patient is admitted so that the room will be free of pollen. It has been found that acute cases are almost immediately relieved.—GEORGE D. SHEATS, *Baptist Hospital, Memphis, Tenn.*

We Use Flannel Masks

MARIE C. ANTE, R.N.
and GEZA de TAKATS, M.D.

THE possible sources of contamination of the surgical field are many. Cole and Elman[1] listed them as follows: (1) mouth and throat of the operating room personnel; (2) skin of the surgeon's and assistants' hands; (3) patient's skin; (4) faulty sterilization in autoclave; (5) suture material, chiefly catgut; (6) gross break in aseptic technic; (7) trauma to tissues, poor hemostasis, sutures under tension.

To these we may add the fluctuations of immunity and changes in the virulence of bacteria, which may convert a subclinical unrecognizable contamination into a manifest clinical infection.

In a recent study[2] were described methods that were utilized to minimize the dangers from the sources enumerated above. Statistical data, based on an "infection sheet" attached to the history of every major surgical case, were presented. As part of our effort to eliminate sources of infection, the evolution of our present mask is presented here.

Seek Perfect Filter

For several years one of us (G. de T.) has been interested in an inexpensive, easily laundered, comfortable mask, which would efficiently filter the exhaled air of bacteria. It has been shown repeatedly by Davis,[3] Walker,[4] Waters,[5] Blatt[6] and many others that the ordinary four to six ply gauze mask is permeable to bacteria and that the adequate surgical mask has not been found.

Arnold[7] has shown, using the air centrifuge of Wells,[8] that when a person gargled with a 1:100 dilution of a culture of B. prodigiosus and then talked into the Wells machine for from ten to twelve minutes, with his mouth and nose masked with the customary gauze mask, 1362 bacteria of the same kind were recovered per ten cubic feet of air. He also showed that the permeability of the mask increased with time. In the first two minutes only 20 bacteria passed through, but the count increased with every two minute period and during the fifth two minutes 317 bacteria passed through per ten cubic feet of air.

Throat Cultures of the Nursing Staff Oct. 21, 1936 to Feb. 9, 1937

Negative on first culture	79
Positive on first culture	20
Negative on second culture	7
Positive on second culture	6
Not recultured	7

Of the 6 positives on second culture, 3 remained persistently positive, 2 became intermittently negative, 1 remained persistently negative. Of the negatives on first culture, 3 became intermittently positive. Cultures were taken once a week.

Obviously, the ordinary six ply gauze mask when worn for an hour or more is incapable of filtering bacteria. In hot weather the masks are often moist when removed and some surgeons even moisten them before use for cooling purposes. Such masks seem quite useless and one wonders whether Hertzler's[9] contempt of masking the mouth or nose does not have some justification as far as the gauze mask is concerned.

Gauze or calico masks containing rubber, cellophane, plastigut or any other impermeable material have not solved the problem. We have tried every one of these. It is true that the impermeable material incorporated into a pocket of the mask prevents a direct spray of bacteria into the wound but it simply deflects the bacterial current and the air of the operating room receives an unfiltered stream of bacteria. The air contamination of the operating room has recently received a great deal of emphasis and the deflector types of mask certainly do nothing to minimize this source of contamination.

Material Must Be Absorbent

Obviously, the proper mask has to fit the face closely and permit free breathing through its texture. When Prof. L. Arnold of the department of bacteriology of the University of Illinois was approached to study the bacteriologic aspects of this problem he had already made some observations relating to the relative efficiency of various textiles to absorb bacteria. Silk, linen and cotton absorbed bacteria poorly. Wood cellulose, in the form of a crêped wadding called "cellucotton," showed remarkable absorbing qualities.

In a series of laboratory experiments Arnold[7] came to advocate the use of cellucotton as an effective air filter. He pointed out that if all the air could be made to pass through the cellucotton mask the bacteria would remain on the cellulose fibers. However, leakage around the edges of the mask, which occurs with the average surgical mask, especially the hood type, produces contamination of the air.

The sterilization of the air in operating rooms, as approached with such vigor and ingenuity by Hart and his associates,[10] is only a partial and certainly an indirect solu-

Miss Ante is operating room supervisor at St. Luke's Hospital, Chicago, and Doctor de Takats is associate professor of surgery, University of Illinois College of Medicine.

[1] Cole, W. H., and Elman, R.: Textbook of Surgery, D. Appleton-Century Co., Inc., New York and London, 1936.

[2] de Takats, G., and Jesser, J. H.: Postoperative Infection; Measures of Control, in press.

[3] Davis, J. S.: The Importance of Adequate Masking During Operations, Ann. Surg. **100:** 1008, 1934.

[4] Walker, J. S.: How Can We Determine the Efficiency of Surgical Masks? Surg. Gynec. and Obst. **50:**266, 1936.

[5] Waters, E. G.: Adequate Surgical Masking: Problem and Solution, Am. J. Surg. **32:**474, 1936.

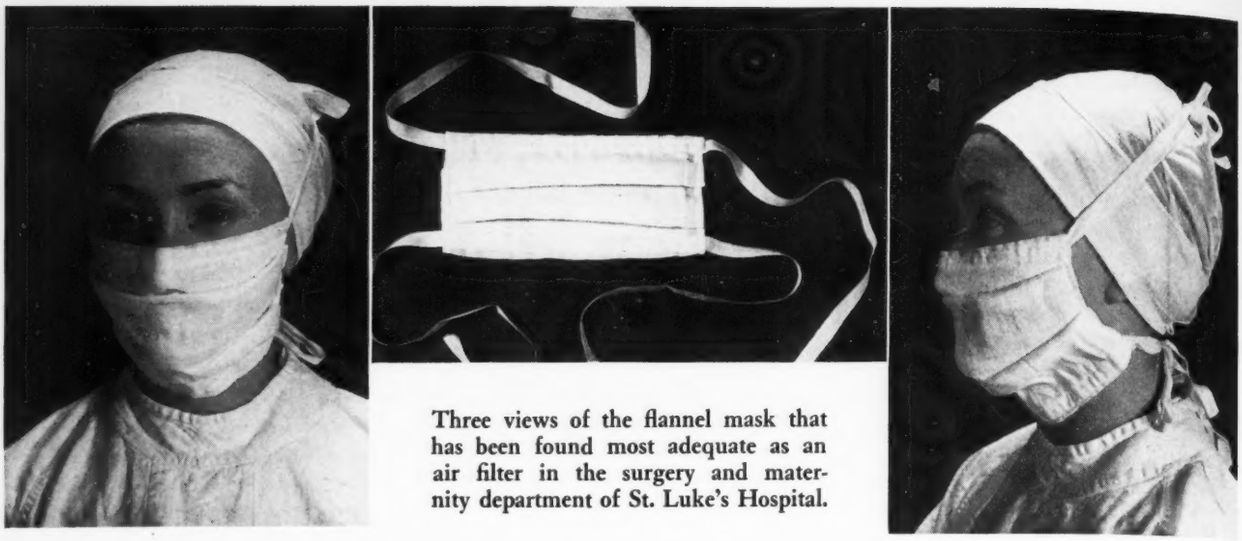
[6] Blatt, M. C., and Dale, M. L.: A Bacteriological Study of the Efficiency of Face Masks, Surg. Gynec. and Obst. **57:**363, 1933.

[7] Arnold, L.: A New Surgical Mask, Arch. Surg. **37:**1008, 1938.

[8] Wells, W. F.: On Airborne Infection: 1. Apparatus for the Study of the Bacterial Behavior of Air, Am. J. Pub. Health **23:**58, 1933.

[9] Hertzler, A. E.: The Horse and Buggy Doctor, Harper Bros., New York, 1938.

[10] *(a)* Hart, D.: Sterilization of the Air in the Operating Room by Special Bacterial Radiant Energy, J. Thoracic Surg. **6:**45, 1936. *(b)* Id.: Sterilization of the Air in Operating Room by Bactericidal Radiant Energy, Surg. **1:**770, 1937. *(c)* Hart, D., and Schiebel, H. M.: The Rôle of the Respiratory Tract in Contamination of Air; a Comparative Study, Arch. Surg. **28:** 788, 1939.



Three views of the flannel mask that has been found most adequate as an air filter in the surgery and maternity department of St. Luke's Hospital.

tion of the problem. As long as it is generally admitted that the degree of air contamination in any room is directly proportional to the duration of occupancy, the number of occupants, the percentage of carriers and the intensity of the air pollution, effective masking seems to be the crux of the situation. The elimination of the carriers has been tried in different services (Meleney,[11] Hart[10]) and has been found to be impracticable. Cultures from the nose and throat change from day to day and completely to eliminate the resultant bacterial content of the air would be difficult if not impossible.

The training of student nurses is seriously hampered by their frequent and repeated elimination from the operating room; interns and attending men in a busy general hospital cannot be made to stop their work if their throat cultures prove to be positive.

At St. Luke's Hospital, Chicago, the attempt was made for a short period to eliminate all student and graduate nurses from the operating room and the maternity wards whose throat cultures were positive for hemolytic streptococci; the Staphylococcus aureus carriers were not included in this group.

The table shows the result of throat cultures on a total of 99 student and graduate nurses over a ten week period. It is obvious from this greatly abbreviated report that in the fall of 1936, 20 per cent of the nursing staff connected with operating rooms or maternity wards carried hemolytic streptococci. After a short period of elimination of the carriers the nursing school properly pointed out that as long as the attending and intern staffs were not cultured the prophylactic value of such a measure was dubious; furthermore, the training of the student nurses was seriously hampered.

In a personal communication Dr. Frank Meleney stated that during the late winter and early spring months the incidence of positive throat cultures in the personnel amounted to a peak of 35 per cent; they still maintained (Feb. 15, 1937) an elimination of the carriers for the Sloane Hospital for Women, New York City, as it was felt that on the maternity service the nurses come into much closer contact with the patients.

For more than a year the cellucotton masks as suggested by the work of Arnold[7] were in use. Eight layers of cellucotton were placed in a pocket of a large gauze mask; a flexible metal band was inserted into the upper part of the mask, which was bent to fit the nose of the individual doctor or nurse (Walker[3]) and which prevents steaming of the glasses.

There were two objections to this mask: (1) it required considerable time to place the cellucotton in the pocket and (2) breathing through the gauze mask with the eight ply cellucotton was not easy. Some surgeons refused to wear the mask. A few nurses complained of a stuffy odor when the mask was worn for a long time, as, for example, on the maternity wards.

We then tried a commercial mask, which had an excellent cut to fit any type of face and which contained, as a filter, a variety of compressed cotton. The bacteriologic work on the efficacy of this material has been reported by McKhann and his associates.[12] It seems not inferior to cellucotton.

Finally, the operating room committee adopted a hospital-made flannel mask, which has now been in steady use for almost two years. Its use has been adopted by the Canadian Red Cross for Canadian Medical Services. At present, it is in general use at our hospital.

The mask is made of a 9 by 6 inch piece of Alaska flannel bought on the market for 9 cents a yard.[13] It is inserted between two layers of a 44 by 40 thread mesh gauze. There is one thickness of this gauze on each side.

An ordinary piece of ½ inch tape 44 inches long is sewed along the upper and lower borders of the mask. Two 1 inch tucks are taken at the two sides of the mask, shortening its length to 4 inches and ensuring a close fit over the cheeks. A pocket is left for the insertion of a flexible metal band for closer fit on the nose. The cost of the mask to the hospital, including material and labor, is 5 cents. It can be resterilized many times.

[11]Meleney, F. L.: Infection in Clean Operative Wounds, Surg., Gynec. and Obst. **60**:264, 1935.

[12]McKhann, C. F., Steeger, A., and Long, A. P.: Hospital Infections, Am. J. Dis. Child. **55**:579, 1938.

[13]The types of canton flannel that serve as effective bacterial filters have been given to us by Dr. C. F. McKhann as Cinderella, Edwards SF-124 and Edwards SF-125. We gratefully acknowledge Doctor McKhann's help. A study of these masks is being continued.

Hospital Day Hits New High

With Nation-Wide Participation

CHURCHES, schools and other public institutions, as well as business concerns and utility companies, cooperated with hospitals the country over to make May 12 the most effective National Hospital Day in the history of the celebration. Through the mediums of radio, the press and outdoor advertising large communities and small were invited to pause to consider their relationship with the hospital and to become better acquainted with its functioning.

The Michigan Hospital Association and the Detroit Hospital Council, which last year won the national award for hospital councils offered by the American Hospital Association, again presented a splendid publicity campaign. The core of the program was a series of catchy thought-provoking postcards and letters sent out daily to every hospital and sanatorium in the state.

Publicity Widespread

Stores were persuaded to dress their windows with National Hospital Day displays, dairies placed 200,000 milk bottle collars on deliveries made on May 11, one large bakery wrapped 180,000 loaves of bread in National Hospital Day papers to be delivered to homes on May 10, business organizations tucked informational literature on the day in the pay envelopes of employes and transportation vehicles carried placards publicizing the event.

The Michigan committee, under the chairmanship of Carl Flath, distributed 10,000 hospital day bulletin cards, 15,000 window streamers, 20,000 fold cards, 10,000 Florence Nightingale pamphlets to be imprinted with the hospital's name, 150,000 folders, 20,000 invitation cards, 10,000 postcards, 40,000 stickers and 1000 display cards to the member hospitals in the state.

Fifteen Michigan radio stations carried spot announcements and several feature programs on National Hospital Day, as well as various informal round table discussions, some of which were presented by local high school groups. School superintendents throughout the state were urged to arrange conducted tours through hospitals for their pupils.

As an additional incentive to its member hospitals, the Illinois Hospital Association offered a bronze wall plaque to the hospital in the state presenting the most worthwhile observance, as did various other state hospital associations.

In Chicago, an extensive publicity effort was made in the form of numerous window displays in the Loop, posters in street cars and elevated stations, announcements from the pulpits and placards in store windows and in the corridors and on bulletin boards of various public buildings.

Of particular prominence in the Chicago campaign was the striking billboard sign posted on Michigan Avenue inviting the public to visit hospitals on May 12. Another innovation in Chicago's publicity program was a sky banner flown over the city for several hours on Sunday, May 11.

A vesper service in memory of Florence Nightingale was held at Galesburg, Ill., to which nurses from the surrounding communities were invited.

Tulsa, Okla., began its celebration on May 12 with a parade at 1:30 p.m., consisting of 10 bands and a large number of floats featuring various phases of hospital service. Activities of Tulsa's National Hospital Day committee became so widespread that it was necessary to establish a separate office to conduct pre-celebration business.

In Indiana, as well as in most of the other states, a governor's proclamation for observance of May 12 as National Hospital Day paved the way for subsequent publicity in the form of floater announcements over local radio stations, news releases to newspapers and letters to hospital administrators.

National Hospital Day radio programs began with "The Hospital and the Community," presented over station WGN, Chicago, on May 8, in connection with the Tri-State Hospital Association. Dr. Benjamin W. Black, Irving S. Cutter and Ronald P. Boardman participated in this discussion.

On May 10 Arnold Emch, assistant secretary of the American Hospital Association, spoke over station WBBM on the subject of education in hospitals.

The University of Chicago round table broadcast on May 11 was devoted to a discussion of defense and health by Dr. A. C. Bachmeyer, Prof. Louis Wirth and Col. Leonard G. Rowntree.

Alexander McQueen devoted his entire time on the air on May 12 to an interpretation of the significance of National Hospital Day, and Meta Pennock of *Trained Nurse and Hospital Review* broadcast from New York City on the same subject.

The final radio presentation was made over NBC on May 12 when Doctor Black from San Francisco opened a round table discussion conducted in Chicago by Doctor Bachmeyer, Dr. Malcolm T. MacEachern and C. Rufus Rorem.

Universal Open House

Demonstrations, tours of the institutions and "baby homecomings" were popular items on hospital programs for the day. Open house was almost the rule and many institutions took this opportunity to introduce new nurses' homes, recent additions and wings or memorial rooms to the public.

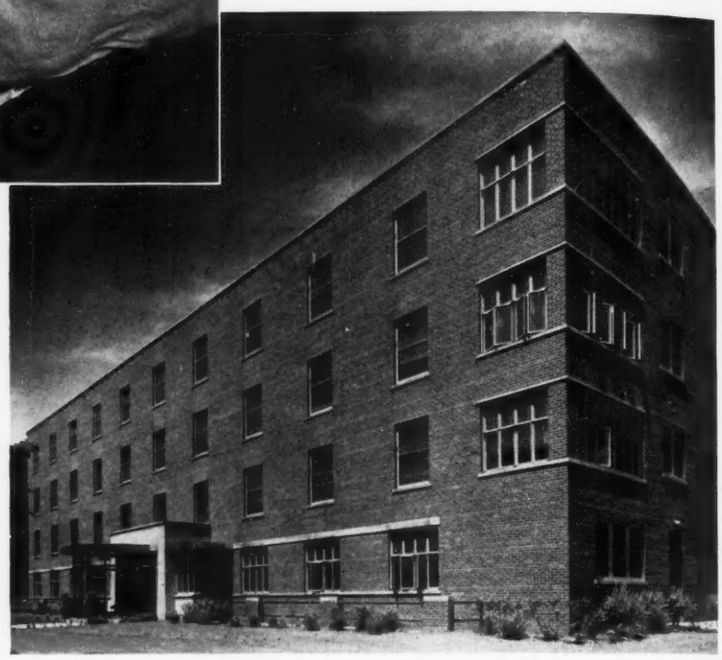
As an aid in entertaining these guests, the National Hospital Day committee, under the general chairmanship of Albert G. Hahn, provided hospitals with literature giving specific information on how the day's events might be conducted to the benefit of both the hospital and its visitors.

Through service plan organizations, the entertaining and instructive film, "Worries Away," prepared by the Associated Hospital Service of Philadelphia, was made available to hospitals.

A Tour of

VICTOR M. ANDERSON
Administrator

MAGNEY, TUSLER & SETTER
Architects, Minneapolis



Right: Of fireproof construction throughout, the four story addition to Abbott Hospital, Minneapolis, houses boiler room, kitchen, laundry, administrative department and operating suite in addition to patients' accommodations. Above: Nursing art room. Below: One section of the modernistically appointed lobby looking toward reception room.

Abbott Hospital

Plant Expanded and Remodeled

CONSTRUCTION DETAILS

GENERAL DATA: Four story and basement addition designed to increase capacity to a total of 150 beds and to add new boiler room, kitchen, laundry, entrance and administrative department, operating suite and patients' accommodations. Alterations and remodeling of old building carried out simultaneously.

CONSTRUCTION: Brick exterior, fireproof throughout.

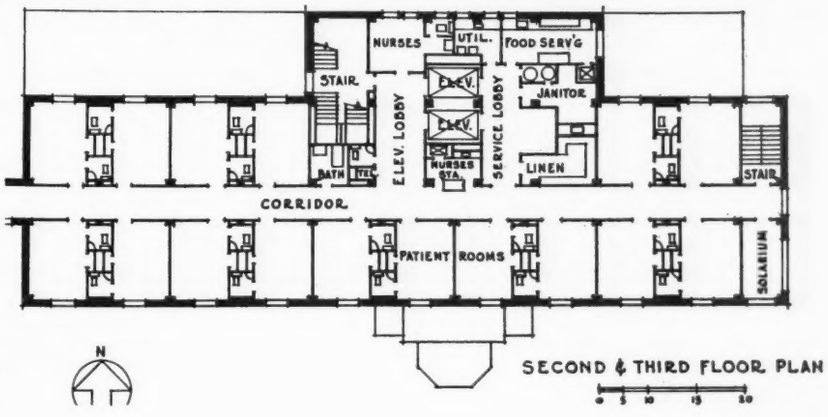
FLOORING: Boiler room, incinerator room, laundry, refrigerator room, sterilizing room, general storage room and receiving room, cement. Kitchens, red quarry tile. Toilets and scrubup rooms, terrazzo; operating rooms, terrazzo with a brass grid. Other locations, mastic tile floors and bases.

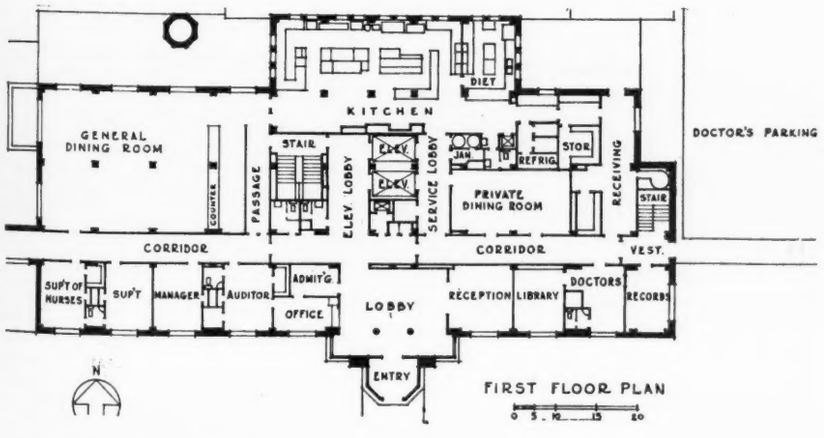
WALLS AND CEILINGS: Lobby paneled with Tasmanian oak. Other locations, mostly plastered walls and ceilings. Operating room, colored tile in tan, blue and two shades of green. Sterilizing room, cream colored tile. General entrance, part of general kitchen, main dining room, nurses' stations, halls, lobbies and corridors, acoustically treated. Boiler room ceiling, sheet cork insulation.

BOILER ROOM AND HEATING: Two 125 h.p. steam steel boilers equipped with coal stokers and two boiler feed pumps. Provision for additional boiler for future nurses' home and two additional stories on new building. Two-pipe vacuum heating system with duplicate return pumps. Concealed copper convector radiators. Hot water heaters and storage tanks. Electric service lines and distribution equipment. Mop cleaning machine. Sewage bilge pump. Large windows removable to admit new machinery. Brick setting incinerator with garbage can washer and paper baling machine.

LAUNDRY: Three tumbler washers, two extractors, two tumbler driers with lint eliminator, curtain stretching cabinet, 110 inch six roll flat ironer with ventilated hood, two steam pressers, soap cooker, starch cooker, drinking fountain.

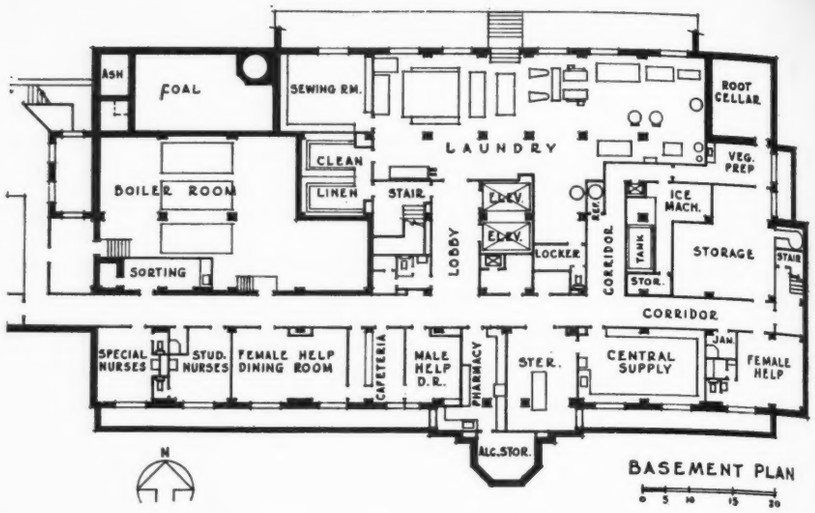
REFRIGERATION: One compressor with brine tank for ice making, one compressor for kitchen cold counter and walk-in refrigerator. Unit refrigerator in bakery, diet kitchen, floor food serving rooms.

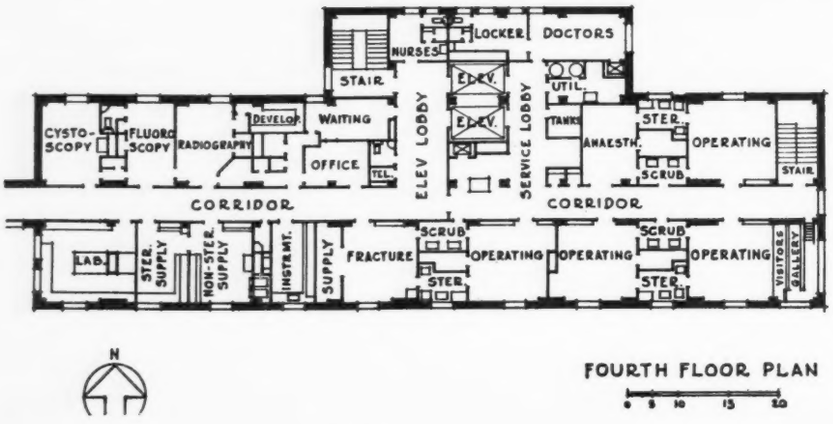




Top: One of the spacious private rooms in Abbott Hospital, all of which are equipped with an electric call system. Above: Second and third floor plan for the new addition. Left: First floor plan. Doctors have a private entrance to the hospital. By passing from their library and adjoining cloak room through the service lobby to elevators, staff members do not come in contact with hospital visitors on the main floor.

Right: The floor plan for the basement showing location of laundry, boiler room, storeroom and central supply. Below: A section of the nurses' dining room. Bottom: Plan shows fourth floor layout. Each operating and fracture room on this floor is equipped with an individual air conditioning unit. Air is not recirculated and is exhausted through a floor opening to the explosion-proof fan in the penthouse on the roof.





VENTILATION AND AIR CONDITIONING: Each operating and fracture room equipped with individual complete year round air conditioning unit; compressor in roof penthouse. No air recirculated. Air enters operating room near ceiling and is discharged through scrubup and sterilizing rooms to explosion-proof type of fan in roof penthouse. Equipment in roof penthouse also supplies filtered and washed air to all lobbies, corridors and halls, maintaining slight air pressure when windows and doors are closed. Air enters patients' rooms and is exhausted through toilet and bathrooms.

LIGHTING AND WIRING: All windows weather stripped and equipped with venetian blinds. Laundry lighted with large light well, its sloping wall painted with light-reflecting paint. Indirect ceiling lights in patients' rooms with night illumination by recessed louvered fixture in wall under bed controlled by mercury noiseless switches. Combination electric fixture on wall at head of bed provides two nurses' call plug-ins, duplex electric plug-ins, radio power service and radio antennae.

CALL SYSTEMS: Electric nurses' call; paging annunciator in corridor walls opposite nurses' stations.

ELEVATORS AND DUMB-WAITERS: Two fully automatic elevators. Automatically controlled dumb-waiters with message tubes for food service and for pharmacy.

KITCHEN: Ranges, broiler, fry kettle, steamer, towel drier, bake oven, two stock kettles in central group with ventilating hood. Mechanical dishwasher and glasswasher with ventilating hood. Baker's department. Hot food and beverage group and cold counter. Silver cleaner. Meat counter. Three compartment walk-in refrigerator. Service by dumbwaiter. Toilet room so arranged that dietitian can supervise handwashing by employes before their return to duties.

PATIENTS' ROOMS: All 12 by 16 feet, with 3½ foot doors. Rooms provided with one or two wardrobe closets, backs insulated and removable to provide access to pipe spaces. Flush wood doors set in flush steel frames throughout.

COSTS: Total cost of new section (not including $70,000 for modernization of old building), $500,000. Cost per cubic foot, 68 cents for building, 10 cents for equipment. Cost of air conditioning five major operating rooms, $7895.

Planned Economy in the Nursing Office

JANNETTE M. SELFRIDGE, R.N.

A DIRECTOR of nursing service is not necessarily, or even commonly, trained in office organization methods and, as time is required for planned office economy, a vicious circle may have been set up long before it is recognized.

No amount of planning will offset the actual inadequacy of assistance all too frequently encountered in the nursing office. However, planning may be expected to stimulate alertness to the desirability of accomplishing routine duties with dispatch and economy in order to release personnel for its own particular functions.

Let us assume that the following functions are fundamental for any nursing office: (1) personnel selection; (2) placement and movement of personnel, both periodically and in emergencies; (3) counseling and health supervision; (4) patient welfare, involving, for example, adjustments of service and accidents; (5) intradepartmental and interdepartmental coordination; (6) formulation and maintenance of standards, including nursing technics, subsidiary workers' routines and equipment checks, and (7) record-keeping, including time books, placement and vacation schedules and graphs, efficiency records and other personnel files. If there is a nursing school these functions will be varied only in detail and quantity.

The emphasis that may be placed upon any of the above mentioned functions will be related to at least four other functions that are only incidentally administered by the nursing office in the large organization. Obviously, they are not incidental to the organization as a whole.

These functions are: (1) distribution of equipment and supplies, such as surveying and relaying of requisitions, providing emergency replacements of breakage, lending unusual equipment not kept on the wards, dispensing drugs out of drug room hours; (2) ordering and selection, either independently or in advisory capacity, of new or replaced ward equipment, office supplies and devices, and planning and proof-reading printed forms, notices and bulletins; (3) public relations, such as the control of visitors, photographers and newsgatherers and maintenance of contacts with alumnae, staff physicians and possibly members of their families; (4) admissions and collections, particularly through emergency channels during the night.

On the basis of these somewhat arbitrary divisions, we may proceed to survey our individual institutions. The proportion of time given to the several functions may be evaluated in terms of the aims and ideals of the institution. We shall then find ourselves in a position to budget the time of our workers realistically and to select the pattern to suit the cloth.

A survey can be fitted into the day's work by assuming the attitude of a director of nursing service entering a new position or of one about to train a new and inexperienced secretary. Information must be gathered as quickly as possible from many casual sources, as well as from many deliberate ones.

Selecting the personnel pattern to suit the administrative cloth, preparing a procedure manual to serve the dual purpose of interest and application, and budgeting time are but three of the major economies that can effect cooperation and efficiency in the nursing office program

Mental energy is best conserved and confusion avoided by making systematic notes. It is a mistake to discard these notes as soon as the information they contain is assimilated in practice. To capitalize on them, the information may be assembled and worked up into an office manual for use when comparable situations recur.

An alert director and six floor supervisors, who were initiated in turn in the intricacies of office assistantship, built up an excellent manual in this manner. When beset by a wasteful turnover resulting from the lamentably small salary she was able to offer, a busy director conserved time by enlisting the interest of each new secretary in such a project.

Training in the trick of immediate organization of miscellaneous and unrelated material may be simply acquired by the constant use of a loose-leaf notebook. The material is gradually and systematically collected under appropriate headings, which may be planned ahead and subdivided or revamped as needed.

The organization of a nursing office should guarantee that the satisfactory work distribution evolved by an individual administrator will be carried over to a successor.

When frequent changes occur, subtle and insidious effects are probable. The more permanent members of the staff who are able to be of assistance during the orientation period are ultimately bound to build up feelings of frustration or over-importance. The superior preparation of the director will be granted, particularly as she receives salary recognition for it, but will not necessarily be patent in many situations of practical importance. Until she has assimilated much common detailed information to a subconscious level, she may be unable to demonstrate an ability to plan with effective and impressive foresight. It may well require a year before the abilities of one of the best prepared workers in the organization can be properly capitalized.

This situation is particularly bad if it involves a nursing school. But in any case the degree of disruption caused by turnover might startle the

administrator of the institution if he could measure it as he would in the business office.

Adjustment to an unfamiliar rhythm in the matter of preparing annual reports and preparing application papers for state board examinations is not automatic. If no recorded plan of seasonal procedure is on file, undue bunching and rush of work, with accompanying inaccuracies, are almost inevitable. The reputation of the entire institution may suffer.

The new director of nursing service may, therefore, be able to make an invaluable contribution to the life of the organization if she plans deliberately to organize the information that she receives as though she were preparing it for her successor. Thus, she can prepare her office procedures manual.

A simple analysis of the distribution of the annual office load may be made by the use of an engagement calendar of sufficient size, designed in monthly sheets, squared off into days. Having accumulated the miscellaneous responsibilities under appropriate chronological headings, such as annual, quarterly, monthly, weekly and irregular, they can be posted on the calendar. With a yearly pattern thus spaced, the items may be used as pawns in the game of time budgeting. Such a tentative budget, constructed with due regard to past performance, can be put to test, month by month, throughout a year. A monthly office staff conference will permit evaluation of its efficacy.

Encourage Constructive Comment

The monthly office staff conference will elicit comment upon wasteful patterns of activity. The need for job analyses will arise in a manner that is impersonal yet interesting to the individual worker. Self-analysis will be stimulated, the ground tilled for the constructive suggestions of the director and at the same time any possible feeling that she is perhaps a bit mad on the subject of efficiency allayed.

Calendars also may be used as devices for creating smooth department interaction. Desk calendars, annotated at the conferences of unit heads or in consultation with the assistant in charge of personnel, provide useful signals related to change days and minimize unpleasant surprises. Reminders of dates upon which inventories and efficiency records are due make excuses for tardiness seem doubly ineffectual.

Before undertaking specific job analyses, why not observe the habits and workings of the office as a whole? How many of those frequent interruptions are really necessary? Those that are not invested with human values should be minimized mercilessly.

If, for example, one rarely contacts the seamstress or engineer except at the time when these workers collect requisitions from one's desk spindle, the distraction involved may be useful and justifiable. Otherwise, these requisitions may better be relegated to a bulletin board outside the office proper, where permanent, labeled bull-dog clips will affix them and provide a means of sorting them.

Why use a spindle anyway? A dozen pawing motions may be necessary to retrieve one bit of information that could have been almost as quickly filed by insertion into a small "work organizer." Two motions would produce it in this case. Many a requisition becomes dog-eared and many a letter shredded before they are finally removed from a spindle.

Conservation of the secretary's time is likely to be important. Has she built up a quick reference list of frequently used addresses complete with correct titles or must she frequently refer to the letter files? Such a source will be exceedingly useful when she is ill or changes employment. How does she receive information? Does it come to her in organized form or must it be handled and rehandled before becoming useful?

Need there be so much time wasted in contacting a busy director? In an institution in which the nursing office employed no individual secretary, seven persons, including a doctor, a student nurse, two graduates, a maid and two visitors, appeared within a forty-five minute period and after waiting varying lengths of time went off more or less annoyed. Surely, under such circumstances some regularly available conference time can be planned or directions for intelligent and acceptable use of the call system posted.

Are loans of special equipment made through your office? If so, how are they recorded? It takes time to plan and index a loan book, but an accurate classified recording may be obtained in this manner. Furthermore, you will have a means of estimating the turnover of each article, the likelihood of deterioration from oversupply and the length of service yielded. The most casually trained worker can fill out blank spaces, if he comes armed with a requisition corresponding with the requirements of the loan book.

In relation to personnel direction, how much do you rely upon the verbal instruction of subsidiary workers? If nursing procedures must be reviewed even after they have been demonstrated, is it not likely that an aid or an orderly will need a reference bulletin, particularly if either must be rather hastily broken in by a busy head nurse?

Bulletins Are Helpful

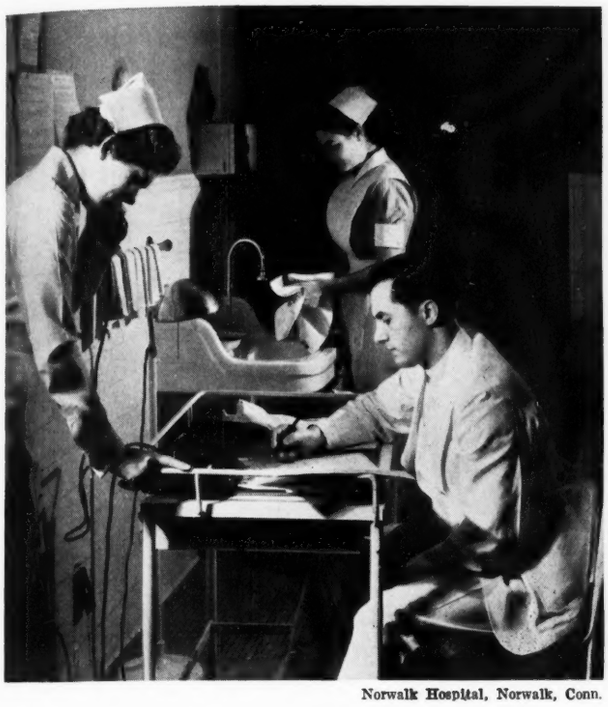
Information bulletins providing a review of instructions can be used with excellent effect if they are simply constructed and are limited in number so that revisions may be quickly accomplished and many editions prevented. During the orientation period they will prove helpful to the supervisor in testing the rapidity of the worker's adaptation. They may be issued for a week, signed and returned, after which the worker may reasonably be held responsible for their contents.

To analyze our functions and to seek to budget time for their effective realization are far from impossible, despite the undeniable fact that the best laid plans must give way in emergency. We should take cognizance of the fact that although hospitals themselves are set up to deal with emergencies and although personnel is geared to function on that basis, since emergencies constantly recur, they can be assimilated as routine.

But to capitalize to the full the creative thinking of our workers, a survey plan that is automatically recurrent or, at least, periodic will be found valuable. We may then exercise vigilance in relation to that ever growing underbrush, keep our vision clear to observe the trees and on occasion gain a really telling view of our forest as a whole.

How to Organize and Manage a
Venereal Disease Clinic

MORRIS H. LEVINE, M.D.
Brooklyn, N. Y.



Records of patient appointments and treatment are kept on active file in the office of the venereal disease clinic.

Norwalk Hospital, Norwalk, Conn.

THE successful operation of a venereal disease clinic presents peculiar problems and because of these problems the operation of such a clinic requires a large and well-trained staff, as well as intensive supervision.

Some psychic elevation has been given the afflicted patient by freer discussion and a more charitable attitude toward venereal disease and by public knowledge of the fact that it is possible to eradicate the infection in relatively few years. However, the necessity of attending a clinic for as long a period as the treatment of syphilis may require is likely to produce a psychic wound that must be allowed for if treatment is to be completely successful.

A patient who has recently begun treatment at a venereal disease clinic may have a variable reaction depending upon the following factors: the manner of the acquisition of the disease, if known; how the diagnosis was discovered; the patient's inherent personality and intelligence; the attitude of his family and friends toward his affliction; the recency and frequency of exposure; the presenting symptoms, and his esteem for his fellow patients. The painful method of introduction of medication, the occasional infiltration of the perivascular tissues and the occasional occurrence of reaction to medication are factors that further complicate therapy. In addition, there is the effect of pressure from social agencies in requiring the patient to report regularly for treatment when he himself feels quite all right and believes these visits are unnecessary.

Thus, there is a background for a vast psychic difference between the patient in a venereal disease clinic and a patient who voluntarily and eagerly attends a nonvenereal disease clinic where he presents himself with self-recognized symptoms and signs and where he can note his own progress under treatment. Moreover, the patient in a nonvenereal disease clinic is more likely to regard the condition of his fellow patients as a matter of ill fortune rather than of ill character.

It is the policy of the Department of Hospitals of New York City to pay physicians who work in venereal disease clinics. This introduces a factor of some magnitude in a clinic, for the financial consideration attracts a larger number of staff men and permits a better selection. The remuneration the clinician receives acts as a stimulant to further his knowledge of venereal disease control. In addition, the administration has a stronger influence over him with the result that better records are kept, a deeper sense of responsibility is sounded and regular and prompt attendance is obtained. Definitely, one may conclude from our experience at Greenpoint Hospital, Brooklyn, N. Y., that pay for clinicians is to the advantage of the hospital and patient.

Originally, it was planned to hold three clinic sessions per week with six doctors in attendance, four of whom were selected from the genito-urinary staff and two, from the gynecologic staff. It was decided, because of factors that must be considered in mixing sexes in a single waiting room, to adapt the plan to permit four sessions per week, two for males and two for females.

The attendance schedule of the physicians has been staggered so that on men's treatment days the four members of the genito-urinary staff attend with one gynecological member on one day and with the other gynecologist on the other men's day. Both gynecological members attend, with half the genito-urinary division of the staff alternating, on women's treatment days. Children under 12 years attend the clinic for females. Thus, five clinicians attend each of the two sessions for males and four, each of the two sessions for females, making a total of 18 physicians' sessions per week.

The sexes are kept separate, except in the unusual occasion when an urgent visit is required. Two nurses,

Doctor Levine is former physician-in-charge of the out-patient department, Greenpoint Hospital, Brooklyn, N. Y., a division of the Department of Hospitals of the City of New York. Dr. Leon Izgur, former medical superintendent of Greenpoint, was co-author. He is no longer living.

one male and one female, are assigned to the clinic. One sets up and sterilizes while the other is active in the clinic, alternating according to the sex being treated. In addition, there is either a male or a female attendant on duty during every clinic session.

All patients are registered at the central record department of the Department of Hospitals between 9 and 10 a.m. and between 1 and 2 p.m. Venereal disease records are kept in a separate file there. Appointments are kept on an appointment card. This card is used at Greenpoint Hospital, which is one division of the city out-patient department. The appointment system serves, first, for the purpose of indicating delinquency, which may require follow-up work, and, second, for spreading attendance more evenly.

Immediately on expiration of the registration hour a clerk, who is permanently assigned to the social disease clinic, leaves the centralized registration desk for the venereal disease clinic where he arranges the charts and appointment cards in the order in which the patients registered, segregating them into gonorrhea, lues and new patient groups. He further divides the lues group into those for whom treatment for the day is already prescribed in a course of therapy and those who are to be seen by the physician who directs the course of treatment.

How Patient Is Routed

The first clinic contact of a new patient is with a physician who records the history. The patient is then passed on to the examining cubicle where physical findings are recorded. Leading from the two interviewing rooms is a hallway with a lengthwise partial partition (in which there is a door), originally planned to separate the cubicles for men and women. This divided hallway communicates with cubicles on either side. At the farthest end of the hallway is a sterilizing room.

Separate cubicles are used for physical examinations, for taking blood for serologic study, for injection of arsenicals and for injection of heavy metals. Another cubicle with a recovery cot is set aside for spinal punctures and two cubicles are used for gonorrheal work. Gonorrheal smears are done by a technician in the out-patient department laboratory; dark field examinations, by a physician in the clinic.

Special duplicated forms on which a course of treatment can be outlined have been drawn up to facilitate records of treatments. As the patient's visit is being completed the doctor writes the date of the next appointment on the treatment sheet. The charts are then received in small groups by the clerk, who transcribes the next appointment date to the appointment card and also to the back of the patient's clinic registration card. The appointment cards are filed chronologically to facilitate handling.

Follow-Up Procedure

The appointment cards remaining in a day's file after the clinic is finished represent the cases that may require a follow-up letter. Usually, a second week is allowed to pass before a letter is sent out. If after a reasonable interval has elapsed there is no response to a follow-up letter, the case is referred to the bureau of social hygiene, which acts somewhat as a centralized social service division of the department of health, being mainly intended for practicing physicians.

In many instances the report of the field investigator to the bureau of investigation, in a study of the financial status of the prospective patient to determine his eligibility for charity treatment, brings to light important information useful for follow-up work. Sometimes it is a matter of carfare which a home relief patient cannot afford and which may be allowed by the department of welfare. If the bureau of social hygiene is informed that the patient is obtaining assistance from home relief, board of child welfare, W.P.A. or any other social agency, it may be able to enlist the aid of the agency social worker. If contact with this agency social worker is made directly from the hospital, a signed authorization empowering the hospital to reveal his diagnosis should be obtained from the patient.

In the case of a patient on parole, delinquency in treatment may be considered a violation of his parole and communication with the parole officer may prove effective. Such extreme measures are seldom necessary but may be held in reserve. The vast majority of patients are inclined to be cooperative, sometimes for the sake of secrecy and quietude. A removed patient may be traced by the bureau of social hygiene through a utility company, a friend, relative or an employer.

Bureau Institutes New System

The bureau of social hygiene also has instituted a new system aiming toward close follow-up control of syphilis in pregnancy. The reports of cases of venereal disease that are sent to the board of health of New York City report pregnancy also, including how far the pregnancy is advanced and where the patient has been referred for treatment.

At the bureau of social hygiene each new pregnant syphilis case is given a number in order to ensure secrecy and the clinic reporting the case is informed of this number. Each clinic also is given a number. Several postal cards, on the back of which is a printed form, are given to the clinic for each case. This form bears the patient's clinic number, the number of the clinic reporting the case and the date. These cards are sent to the bureau of social hygiene once a week to report whether or not the patient has received treatment during the past week. There is a space for indicating whether arsenicals or heavy metals have been used during the past week. If the patient did not receive treatment during the week, a request may be made for a home visit by the bureau of social hygiene. There is also a space to be filled out when the case is terminated.

After a pregnant syphilis patient has been delivered, a cord Wassermann reaction and an x-ray examination of the long bones of the baby's body are taken. In addition, studies of the placenta are made in the pathology department. If the diagnosis of congenital syphilis is established, the baby is referred to the clinic with its mother for treatment.

A social worker should be assigned solely to the venereal disease clinic to counsel patients, to find out the details of the patients' living conditions, to do follow-up work in the field and to help induce "contacts" and family to submit themselves to examination and treatment when necessary.

What Hospitals Are Doing

To Improve Employe Morale

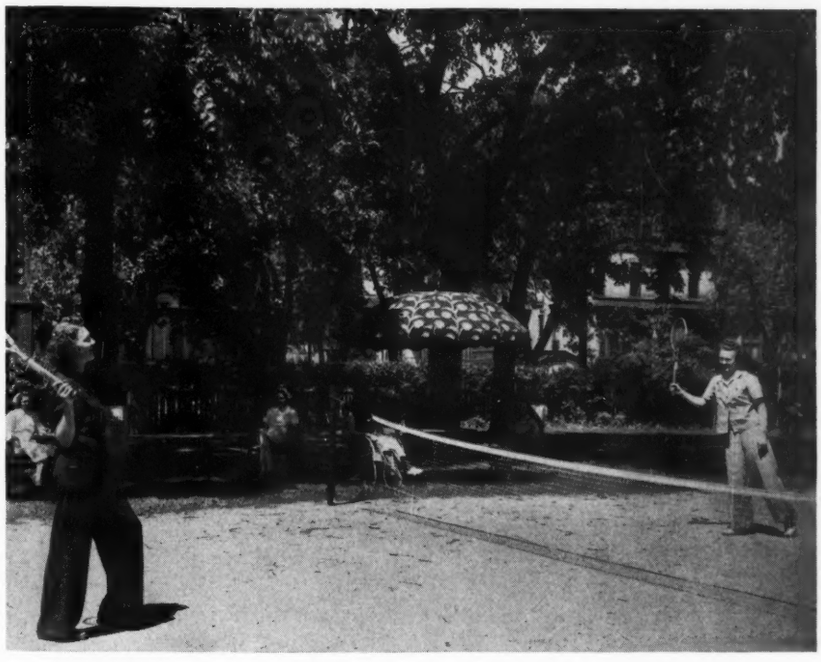
WITH personnel turnover in hospitals at its highest peak in recent years as a result of the national defense emergency, the problem of keeping employes content is a particularly pertinent one. That hospitals are alert to the situation and are taking active steps to improve morale is evidenced by answers to a questionnaire sent out recently to a group of 13 small institutions.

Social and recreational activities are the most popular devices for maintaining good spirit among the employes in the majority of these hospitals.

"The morale of our employes is excellent," writes Dr. Charles E. Holzer, Holzer Hospital, Gallipolis, Ohio. "In our school of nursing, all students are given tickets for a season's swimming at the municipal pool if they wish. A tennis court is equipped and maintained for the use of hospital employes. The school of nursing is given $10 a month to be used for entertainment; in addition, the nursing school sponsors two or three dances a year, to which doctors, technicians and office employes are invited."

At Mary McClellan Hospital, Cambridge, N. Y., social events are given periodically for professional personnel, according to K. Frances Cleave, superintendent. "We encourage our personnel to participate in a recreational program on the 100 acres of hospital grounds. There are several lakes close by for swimming, mountains near enough for hiking and a tennis court is maintained on the hospital grounds. Food for picnics is provided during seasonal months. In winter, skiing facilities are accessible to the hospital."

Other hospitals have bowling teams, dramatic clubs, picnics, informal social gatherings and one even provides its employes with facilities for fishing. The Underwood Hospital at Woodbury, N. J., has built a recreation room in the basement of the nurses' home and has equipped it with card tables, ping-pong tables and an area for deck shuffleboard.



Tennis courts on the grounds provide opportunity for healthful recreation.

In regard to insurance coverage for employes, Dr. R. A. Bowdle, Steptoe Valley Hospital, East Ely, Nev., explains that his hospital sponsors an optional life insurance plan for employes, of which the employer pays one half the premium. Batavia Hospital, Batavia, N. Y., has recently adopted a $1000 term group insurance plan; each employe participating pays 70 cents a month and the hospital pays the balance.

Helen B. Baird, superintendent of Christian R. Holmes Hospital, Cincinnati, says: "We have a retirement provision for our personnel as well as a hospital care plan."

Employes of Holzer Hospital, Gallipolis, Ohio, are protected by hospital insurance, unemployment insurance and old age benefits, Doctor Holzer reports.

Several of these administrators encourage the personnel to take advanced training courses and some of the hospitals occasionally sponsor lectures.

"About one third of our nurses are taking work at the University of Cincinnati toward a B.S. degree," Helen Baird of Christian R. Holmes Hospital, Cincinnati, writes. At Irvington General Hospital, Irvington, N. J., advanced training courses are financed at the expense of the hospital in carefully selected cases.

There seems to be perfect unanimity on the question, "Are salaried employes more content when they live in the hospital or when they live out?" With slight qualifications here and there, the group choruses: "When they live out!" Here are some of the reasons listed:

Leta Henry, Shawnee City Hospital, Shawnee, Okla.: I have found that no person living in the hospital is as efficient as one who lives outside. A hospital is for sick people.

W. C. Tate, M.D., Grace Hospital, Banner Elk, N. C.: When employes live out they have an opportunity to get away from the hospital environ-

ment for at least part of the time and I believe this is good for personnel morale.

Charles E. Holzer, M.D., Holzer Hospital, Gallipolis, Ohio: The employe has more cash with which to maintain his own home; moreover, administration problems of the hospital are lessened.

Alice C. Cleland, New Hampshire Memorial Hospital, Concord, N. H.: They have their own friends and are more at liberty in a small town to live normal social lives.

Mrs. Eva B. Berry, Batavia Hospital, Batavia, N. Y.: They get more relaxation and change away from the hospital atmosphere.

Lee B. Mailler, Cornwall Hospital, Cornwall, N. Y.: They have an opportunity to become part of the community and to enjoy the social life away from the hospital.

K. Frances Cleave, Mary McClellan Hospital, Cambridge, N. Y.: They have more personal freedom when living out.

Helen B. Baird, Christian R. Holmes Hospital, Cincinnati: It allows a more natural manner of living and helps to stimulate an interest in things other than hospital routine.

O. H. Overland, Grand Forks Deaconess Hospital, Grand Forks, N. D.: The majority of our maids prefer to live in, mostly for the convenience of getting to work, but the nurses definitely prefer to live out as they like to get away from the institutional environment.

Elizabeth Schilling, Irvington General Hospital, Irvington, N. J.: At the present time only 20 nurses of the 65 persons employed by this institution live at the hospital, and we are hoping to be able to give these nurses rent allowances soon. It is no longer necessary to provide housing for employes in the metropolitan area as there are adequate transportation facilities.

Most of our people have their homes and families here in the community and they have a much better attitude toward their work and are not handicapped by living too close to it.

R. A. Bowdle, M.D., Steptoe Valley Hospital, East Ely, Nev.: With the exception of the surgery nurse, the others are more content living outside of the hospital.

Nell Robinson, East Liverpool City Hospital, East Liverpool, Ohio: It is better for the hospital as well as for the employes to have them live away from hospital atmosphere as there are so many hidden expenses attached to having personnel within hospital property.

Only one administrator out of the 13 believes this to be a debatable question. Says J. Russell Butler, Underwood Hospital, Woodbury, N. J.: "We maintain a nurses' home but those nurses who live out are residents of the town and probably prefer to live out, since they receive extra compensation. On the other hand, the nurses from out of town prefer living in the nurses' home provided for them here."

WOMEN'S SERVICE GROUPS

A List of Achievements

• West Jersey Homeopathic Hospital, Camden, N. J., boasts an unusually active women's board and auxiliaries.

As evidence here is a list of their recent gifts: complete developing room for the x-ray department, portable x-ray machine, completely equipped superficial therapy room, radiographic tilt table, plate changer for taking chest pictures and an upright Bucky for taking head pictures. Also, they recently equipped the new physical therapy department and donated, among other equipment, a basal metabolism machine, anesthesia equipment, two tray carriers, three stretchers, three wheel chairs, two microtomes for the laboratory, coffee urns and a dishwashing machine.

Their immediate project is the Camden County horse show, the proceeds of which will be donated to help provide below-cost service to deserving patients. Last year nearly 3000 persons attended the show.

Mothers' Club Helps

• When the Mothers' Study Club of Ridgeway, Pa., was started some ten years ago there was no indication that it would one day be playing an important part in the Elk County General Hospital. The purpose was to encourage the study of child problems and to promote philanthropic work among children.

With the assistance of the state nurse and with the permission of the department of welfare, the mothers established a preschool clinic, which is conducted once a month. It is managed by the members of the club; a doctor and a state nurse are always in attendance. No charge is made for the service.

Shortly after the club was formed the members decided to take an active part in the maintenance of the children's ward of the hospital. Since then new beds have been installed throughout the ward, windows equipped with venetian blinds, draperies supplied, the walls decorated, a new floor has been laid and last year it was voted to purchase an incubator.

Do More Than Visit

• They call it the "Ladies' Visiting Committee" of the Massachusetts General Hospital, Boston, but it has many activities in addition to friendly visiting among the patients in the wards.

These ladies take entire charge of the Christmas decorations and festivities, Mrs. Frederic Deane tells us. They work with the library and the occupational therapy department, they see that the radios are functioning properly, they have a plant committee that oversees the interior decoration of the private patient pavilion and they are about to open a shop in the hospital.

This group takes particular pride in the fact that the freedom granted it has never been abused. Unwritten but binding standards of behavior in the hospital have come into existence through the years and each new member absorbs these as she comes on the committee. Thus the group is proving a valued link between the hospital and the outside world.

It Pays to Ask

• "Why don't you women of the church help our hospital?" Last year when a member of the Ladies' Aid of Roxborough Memorial Hospital, Philadelphia, put this question to a friend, she received the reply: "I don't know; maybe, because we haven't been asked."

Needless to say, she was asked then and there; she was told plainly, in fact, that the hospital needed linens. Thus a "linen club" was started and within two weeks boasted 151 church women who paid dues of $1 yearly, receiving in return a membership card. This year Memorial Hospital has received $217 representing the dues of the Linen Club. And it all came about through the simple question, "Why don't you help our hospital?"

A Lay View of Nursing Education

ALFRED L. ROSE
Vice President of Board
Mount Sinai School of Nursing, New York City

A SCHOOL of nursing is fundamentally an organization having an entity distinct unto itself. Furthermore, it is an educational entity. When we have a hospital and want to create a school of nursing, it must be planned for. It cannot have a principal, a faculty, a curriculum or any of the other necessary attributes unless all are selected and planned by someone. Under our present economic system it must have financial support and business administration.

Problems of operation and equipment are of paramount importance in a school of nursing. Is the school to have a building by itself or is it to be housed with some affiliated institution? How many students are to be accepted? What fees are to be asked? What rules shall be promulgated for the orderly management of the school (quite aside from its educational program)? Will the original plan admit of sufficient expansion without undue difficulty? Will the size of the school equate with the facilities available at the affiliated hospital? Will the hospital support the school or will there be some form of joint participation in the financial burdens?

Many similar questions will readily suggest themselves and the organization must be so planned as to answer all or most of them correctly and satisfactorily.

Assuming that the school is in operation, here are examples of some of the operating problems that begin with the school and probably last as long as the school lasts.

What is to be the relationship between hospital and school? How can constant problems of changing personnel and disagreement on the questions of detail and function be reconciled with justice to both sides? How can the school, as an educational entity, be protected against assuming a position as the last hair on the tail of the hospital-dog and yet avoid having the tail wag the dog? How can the health and well-being of the student body be supervised adequately by members of the medical staff of the hospital without some assertion or claim of preferential right by those who render this gratuitous service? How can the moral well-being of the student body be supervised by persons who have sufficient authority to give their mandates sanction and force?

With all due respect for the ability and sincerity of the men and women who are devoting their lives to problems of education, I believe that the problems indicated, as well as the many problems of an educational nature that will arise, can be solved more adequately by a combination of the science of the educator with the broad human experience of the layman. In many instances professionals espouse theoretical doctrines which, although perfect in theory, may be impractical.

Fundamentally, the board composed of lay members is better equipped to grapple with problems of finance and organization that confront the school of nursing, Mr. Rose believes

Many theories, when strained through the sieve of the layman's practical experience, can be amended without losing much of the theoretical advantage and can emerge as practical working human doctrines. Thus, in all fields, even in the educational one, the advantage of a body of laymen as advisers and balance wheels must have an appeal to the reason of even the most ardent exponent of the educator.

At Mount Sinai Hospital, New York City, the school is not an entity in theory only but is an entity in its very being. Although thoroughly affiliated in every respect with the hospital, it is a separately organized corporation, having its own board of directors, its own officers, its own constitution and by-laws. Its board of directors meets regularly, quite apart from the meetings of the hospital trustees.

In its fundamental organization, however, control by the hospital is assured by the requirement that not less than seven out of the fourteen members of the school's board of directors shall be simultaneously trustees of the hospital. This requirement gives a majority to those who are hospital trustees, because at least three others are members of the medical staff charged primarily with health problems. Similarly, there is a standing committee of the board of trustees of the hospital known as the committee on school of nursing; the president of the school is chairman of this committee and the vice president is vice chairman. This, it seems to us, assures complete liaison between the two societies, whereby they are allied and amalgamated in control.

Our school is technically an affiliate of the hospital, not a subsidiary in the legal sense. The principal, appointed by the school board, is at the same time the superintendent of nurses at the hospital, and she makes her report at every meeting of the board of the school. In her position as superintendent of nurses, she collaborates with the medical director of the hospital and receives the counsel of the board of directors of the school, which dovetails into the main board of the hospital.

Thus, the authority of the medical director of the hospital stems directly

Abstracted from a luncheon address given at the biennial convention of the American Nurses' Association.

from the hospital board and the authority of the superintendent of nurses, indirectly from the same body through the complete affiliation between the school and the hospital board. We find, without the assertion of authority, that there is a fundamental sharing of authority between the hospital and the school, which enables us to live as friends in a cooperative endeavor and not constantly to be irritated by thoughts of divided authority.

A distinct advantage of the lay board comes in the financial field. Few laymen realize the degree of study and application needed to qualify a girl to become a nurse. They accept nurses as "God's gift to suffering humanity" without bothering to wonder how they grew to be nurses. Men of means and of charitable impulse, when they stop to consider the matter or have it brought to their attention, are likely to consider various phases of nursing education as fit subjects for their beneficence. Vacation funds, sick benefit funds, pension funds, funds for additional education and the like can be obtained more readily if the organization has a distinct entity and a lay board that administers its financial affairs than if it is merely one of the departments of a larger institution or lacks lay financial supervision.

The very laymen who comprise its board of directors are likely to talk about their problems and their work among those with whom they associate either socially or in a business way; these discussions bring the school and its financial needs to the attention of men likely to be willing to assist, particularly when they know that the administration of the funds will be directly under those in whom they have confidence.

In the educational field, lack of information available to the average citizen is an obstacle to progress. Each state supervises its own educational standards, but I wonder whether in every state the educational authorities have sufficiently considered the educational prerequisites for nursing education. In many states the educational department has at least a flavor of politics, and personnel is selected, at least partially, because of political affiliations.

A group of important laymen having some political force and wide acquaintance among the powers of state government can frequently be of real assistance either in urging an educational improvement or in vetoing something that it believes would be a disadvantage. The professional member of the faculty can often be more forceful by working through an influential individual or group of individuals who, in their personal and business capacities, owe no allegiance to the department and, therefore, are free agents to speak their minds and their thoughts and to solicit and obtain collateral help from other departments or individuals in the state government.

Consideration should be given to the advantage of a separate board of directors over a mere subcommittee of the main board of the hospital. The school of nursing is more than a department of the hospital. It is charged with the care and supervision of the moral, physical and educational lives of several hundred young women living away from home and parental influence. Individual problems constantly arise and each requires individual attention. Mass education is a necessity but must be supplemented by individual treatment when needed. Infractions of rules amounting occasionally to major misconduct arise and must be separately appraised and separately dealt with. Illnesses, ranging from minor to major acute conditions, are met with every year and each requires specialized attention.

The trustees of the hospital, charged with the obligation of the physical, financial and organizational questions that arise in an institution with hundreds of beds in a highly departmentalized organization, could hardly do more with respect to school problems than pass on basic questions of policy unless the members of the board were prepared to devote a substantial part of their time and attention to the affairs of the hospital and of the school. A relatively small subcommittee of that board would hardly feel the responsibility or the authority that appears to be necessary.

When the school is a separate institution controlled by its own board, both the obligation and the authority are squarely imposed to the end that the relationship between the school and the hospital is that of an affiliated institution.

Each school and each hospital requires its own special treatment. This discussion has centered on one type of organization in the hope that the entire subject may be completely canvassed and aired to the eventual benefit of nursing education throughout the United States.

WHAT THEY ARE SAYING

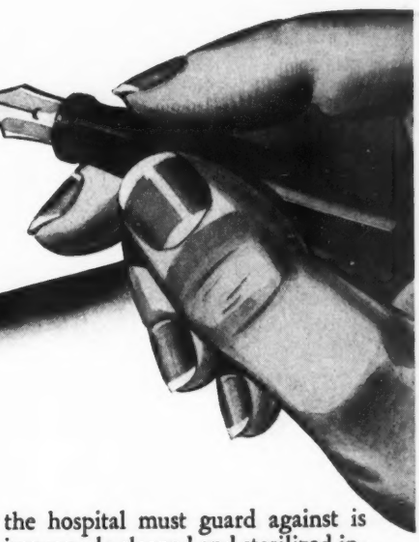
• Although New York City's municipal hospitals are more complex and function now on a mass treatment basis, patients receive a maximum of individual attention. The city hospitals today are taking a keener interest in the individual needs of patients as a result of the example set by voluntary hospitals and the keen spirit of wholesome competition that exists between the voluntary and the municipal systems.

We are considering the individual characters and needs of our patients. The tendency is to break down large wards into smaller units to permit more favorable study and treatment of each case. We realize now that privacy is essential in many ward cases because of psychological factors that weren't recognized thirty years ago.—S. S. GOLDWATER, M.D.

• The trustees or hospital board members have certain definite responsibilities. Theirs is the responsibility for the procurement and provision of funds for the maintenance of the hospital budget. Theirs is the responsibility for establishing the by-laws whereby the hospital is governed. Theirs is the responsibility for selling the hospital to the community and its citizens, regardless of class, clique or financial status. Theirs is the responsibility for the character and quality of the buildings, equipment and facilities provided the physicians, nurses and hospital adminstrator; for the care of and service to the patients, and for research and teaching programs. Theirs is the responsibility for the standard and quality of the professional men who constitute the hospital staff. Theirs is the responsibility for deciding whether a specially educated and trained administrator shall supervise the functioning of the hospital.—CHARLES E. REMY, M.D., *former superintendent, Knickerbocker Hospital, New York City.*

our experience

Reactions are more likely to occur when solutions are made in the hospital. Yours



AS REPORTED* BY 33 OUT OF 35 HOSPITAL EXECUTIVES

This same survey* indicated that some hospital authorities, however, do not yet realize the all-importance of using properly prepared, *tested* solutions. ("Many hospitals emphasized the fact that the condition of the patient may be the controlling factor in producing reactions . . . In addition, too rapid administration of the solution, an excessively high temperature of the solution or other faulty techniques may be responsible for unfavorable results.")

On the contrary, when Cutter Solutions in Saftiflasks are used, these reactions rarely occur. The paramount faulty technique which the hospital must guard against is improperly cleaned and sterilized injection tubing.

It has been definitely proven by many workers, notably by Banks#, that of the many "reasons" given for reactions following intravenous therapy only one is valid—pyrogenic substances present in the solution or in the tubing. Specification of solutions "in Saftiflasks" protects the doctor and the hospital against the possibility of pyrogenic substances being present in the solution, while proper delegation of responsibility in the hospital for cleaning and sterilization of injection apparatus will prevent reactions from this source.

Safe solutions to begin with . . . and safer in use because of the Saftiflask's complete simplicity. Just plug-in your injection tubing!

CUTTER *Saftiflasks*

*Hospitals Report Current Practices in Use of Intravenous Solutions: *Hospital Management, Dec., 1940.* Reprints available.

#A Study of Hyperpyrexia Reaction Following Intravenous Therapy, *Horace M. Banks, A. J. of Clin. Path. 4:3.* Reprints available

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Maintenance of Elevators

WILLIAM W. DAVISON

ELEVATOR manufacturers are constantly improving the mechanics and ruggedness of their equipment, but even the best elevators have a potentiality for trouble and produce operating problems that are exceedingly annoying. Hospital elevators are on twenty-four hour duty, day in and day out, and they should be provided the best possible maintenance inasmuch as their operation involves a constant hazard to life and property.

Too often the hospital elevator is considered of secondary importance and is neglected by the engineer in charge. This is especially true if the elevator machinery is less accessible than other machinery. Sometimes it is placed in a small, hot, dirty machine room in some far corner of the basement or in a lonely penthouse on the roof where it is 105° F. in a broiling August sun or below freezing on a January morning.

A careful and methodical checking and conditioning program, with the object of prevention rather than repairs, should be carried out.

Periodic Inspections

As a general rule, periodic inspections are conducted by municipal, state or insurance inspectors and recommendations are frequently made suggesting various changes or replacements. In some instances, demands for improvements are issued and it is to our advantage to see that such recommendations or suggestions are followed. These inspections, however, should act only as a check on our own inspections, not as a substitute.

The brain and nervous system of any elevator is the control equipment and there is no reason why any engineer who has a good grounding in the fundamental principles of electricity and elevator control equipment should have any trouble maintaining and "shooting" trouble even on the most complicated elevator controllers. It is extremely important, however, that the elevator mechanic be well-trained and expertly supervised to avoid shutdowns and accidents.

Every good elevator maintenance man should be able to read and understand a wiring diagram and should have detailed information on the circuits, adjustments and operation of the controllers for which he is responsible. He should be able to inspect, test and adjust, both electrically and mechanically, the elevator for which he is responsible, making minor repairs where necessary.

The drums, sheaves and gears should be inspected as to their fastenings on the shaft, and the governor and car safety should be examined frequently and carefully for satisfactory operation. As the safeties seldom come into action, they may rust and stick unless examined, oiled and well cleaned at regular intervals; as an additional safeguard, they should be tested annually by the elevator manufacturer.

On traction elevators the drive sheave should be checked for wear, which would cause excess slippage or creeping of cables. On high speed elevators the operation of the slowdown and final limit switches should be tested every thirty days. Governor and safety ropes that look at all worn should be changed at once. If the governor rope is not strong it may snap off when the clamp grips it and, when this occurs, the safety will not act. Wire hoist, counter balance and compensator ropes should be examined often and carefully. They should be condemned as dangerous when the breaks per strand per foot of wire reach the limits set by wire rope manufacturers and insurance companies.

When necessary, wire ropes should be lubricated like any other piece of machinery. Excellent lubricants can be obtained from the manufacturers of elevator rope.

Care in the selection of the lubricant for the ropes of a traction type of machine will prevent slippage; a penetrating rust-resistant lubricant is best for this type of service. Cables should be oiled only when necessary to prevent rust, usually not more than twice a year. They should not be allowed to become dirty or gummy or to throw excess oil on the walls of the machine room or elevator hatch.

Care of Rope Fastenings

An engineer taking charge of an elevator plant may sometimes find that the rope fastenings made by his predecessor are inadequate; he should have them reshackled at once by an experienced elevator mechanic or concern.

On a drum type of machine it should be observed that at the limit of travel the ropes should still encircle the drum at least 1½ times to reduce the stress at the point of fastening. Hoist ropes of drum machines should be reshackled annually to eliminate the possibility of breakage at the shackle.

Tape and serving wire should be removed from the rope at top of shackle after new ropes are installed. I have seen cases in which one half the wires in a strand were broken but were unobserved because they were held in place by the serving wires and covered with tape.

The guides should not be allowed to become gummy and should, therefore, be cleaned and scraped from time to time and freshly lubricated. Gummy guides cause the car alternately to stick and to free itself, making the motion jerky. On a drum machine a bad case of sticking may cause the car to drop a distance great enough to break the cable or to set the safeties. Cylinder oil, well mixed, is a good lubricant for hand oiled steel guides; soft cup grease or a mixture of tar oil and wax is recommended for wood guides.

Guide shoe gibs are an important factor in guide rail lubrication and

smooth car riding. Early guide shoes were cast iron, unlined and bolted securely to the car. Later, they were made adjustable and held to the rail by spring tension and the gibs or liners were made of cast iron or babbitt. The materials used in gibs today are impregnated wood, wood with babbitt inserts, horn fiber, horn fiber with lubricating compound inserts, plastics, bronze, nickel copper alloys and many other metals.

Oil impregnated maple wood gibs improve car riding qualities and guide rail lubrication but they tend to split under severe operating conditions.

Before any type of gib will operate successfully, rails must be in alignment and their surfaces and joints must be smooth. Rails can be surfaced by putting cast iron gibs in the guide shoes and lubricating the rails with a mixture of sulphur and oil. The car is run until the rails attain a good surface; then rails and safety parts are cleaned thoroughly with kerosene, the guide shoe gibs are replaced, the rails lubricated with regular lubricant and operation started on normal schedule.

Under good operating conditions metallic gibs will give 30,000 car miles of service while nonmetallic gibs will give approximately 10,000 car miles.

Lubrication Check-Up

All bearings should be kept well oiled or greased and the gearing should be kept clean. Oil chains should be checked to be sure they are turning freely. The oil bath on a gear type of machine should be kept even with the overflow and should be renewed periodically to remove dirt and grit. New elevators or gears should be oiled more often than machines that have been broken in.

Worm gearings, when new, should be less heavily loaded than when run in if this is possible. A judicious observance of this rule is sure to prolong the life of the gearing considerably. Elevator manufacturers all furnish excellent worm bath oils.

Particular attention should be paid to the lubrication of the thrust or step bearing of gear machines; they should be renewed as soon as they become noisy so that the cavity will not be damaged. Normally, thrust bearings are lubricated automatically by the oil in the gear and require no attention.

The step is generally made adjustable and the adjustment should be such that there is a little end play for the worm shaft, perhaps a scant thirty-second inch; the end play gives the oil a chance to enter between the bearing surfaces at every reversal. If the steps are screwed up too tightly they will be crushed. Gear case oil should be allowed to drip slowly through the worm shaft gland to ensure perfect lubrication of that bearing; this oil should not be used again without straining and then only once to prevent oil dripping from the gear case.

The worm shaft stuffing box must be kept packed with square braided flax packing, preferably a patented molded type. The gland adjusting nuts must be tightened evenly to prevent binding and cutting of the shaft but not too hard to prevent dripping of oil.

General Brake Adjustment

Good brake adjustment is largely responsible for the life of the equipment and the safety of the passengers. Two common brake faults are that the car does not stop quickly enough and that it stops too quickly, with an unpleasant jar to the passengers. The failure to stop the car within proper limits may be due to worn or oil soaked and dirty brake linings. If worn to the point where rivet heads are likely to come in contact with the pulley they should be renewed immediately and if oil soaked and dirty they should be cleaned with gasoline or scraped with glass and the oil leakage eliminated. The counter balance must be landed before the brake shoe is removed.

When the brake linings are in good condition and the brake does not stop the car properly, the cause is then in the mechanical or electrical adjustments or in the dynamic braking circuit of the controller if on a D.C. machine. The brake should be adjusted so that when it is released the shoes just clear the brake pulley; 0.015 inch is sufficient clearance. Dash pots, when used on a brake, should be kept clean and in good condition or their action will not be constant. If the dynamic brake circuit should be open it will allow the car to slide. If under this condition the mechanical brake is readjusted to stop the car within reasonable limits, an unpleasant jar will result. A short circuit in the dynamic resistance will stop the car too quickly, but this will generally be accompanied by sparking at the motor brushes. Therefore, when trouble is being experienced with a brake, careful consideration should be given to the electrical circuits as well as to the mechanical features. Adjustment of the various resistances used in circuit with a D.C. brake may improve its operation.

The brake circuits most frequently used contain three resistances; these when properly adjusted provide the desired brake operation. By increasing the auxiliary series brake resistance within certain limits a quicker application of the brake may be obtained. By increasing the parallel protective resistance further speed may be obtained in applying the brake. However, the best results will be obtained by adjusting the auxiliary parallel protective brake resistance. This resistance is effective only when making stops from high speed as it is subject to a relay connected across the armature and will not function during inching operations. The instantaneous application of the brake at terminal landings is accomplished by automatic contacts in the brake relay circuit.

Brakes on A.C. Machines

Brakes on an A.C. machine are quite different from and must be considerably larger than those on a D.C. machine. Brake shoe linings that last many years in direct current elevator service will last only a few months in alternating current service. An A.C. motor cannot easily be used as a dynamic brake, particularly at low speed and, consequently, the mechanical brake must be of sufficient capacity to stop the car from full speed. This is true in the case of single speed A.C. motors; if the multispeed motor is used the motor can be utilized to slow down the car to a speed corresponding to the slow speed of the motor but below this the mechanical brake must stop the car.

In A.C. elevator service the heavy spring pressure required produces an objectionable effect that is difficult to eliminate, the abrupt stop so characteristic in this class of elevator service.

The action of the A.C. magnet is more abrupt in closing and in release than that of a D.C. magnet. This is one reason why oil dash pots are used on many A.C. brakes. A.C. brakes with polyphase magnets immersed in oil need careful attention. It is important that the oil be maintained at the proper level in the brake magnet housing. If the dash pots are not completely covered with oil, air will enter and cause the brake to slam, spraying oil out of the case. The manufacturers furnish a special grade of oil and substitutions should be avoided.

In the past few years dry plate rectifiers for converting A.C. to D.C. for the operation of brakes and controllers have made great strides. They are constructed of copper disks stacked on insulated rods with lead washers between the disks; metal fins are placed every third or fourth disk to obtain effective cooling. On one side of each disk a layer of red oxide has been formed and the disks will allow current to pass from the copper to the oxide surface but will prevent its passing in the opposite direction, supplying a flow of unidirectional current.

Troubles that may occur on elevator controllers are almost limitless in their form. On the simpler types of controllers, faults can generally be located without such trouble. In the more complicated equipment, however, the location of trouble may tax the knowledge of the best elevator engineer.

Numerous causes of improper operation may be found on the controller resulting from contacts that are worn out or are out of adjustment and dirty solenoid plungers.

When contacts are changed, they should be sanded in and adjusted properly. Occasionally, the pins of the different contact arms should be oiled and contacts tested to be sure they have the same spring tension. Fastenings of resistances should be checked and the engineer should be on the alert for cracked tubes and broken grids.

It will be found that systematic care in the maintenance of elevators will go a long way toward obtaining 100 per cent service. During periods of neglect breakdowns are common, but when a system of examination and inspection is introduced depreciation is curbed, weaknesses are shown up, shutdowns are reduced, all with a reduced maintenance cost.

When to Repaint the Ceiling

AN INGENIOUS cost calculator that shows how often ceilings should be repainted to obtain maximum lighting efficiency at lowest cost is illustrated at the right. This calculator takes into account the economic balance between the cost of light absorbed by dirty or dingy ceilings and the cost of maintenance. Using it, the painter or engineer can readily set up the most economical cleaning or repainting program to meet individual requirements wherever indirect or semi-indirect lighting is employed.

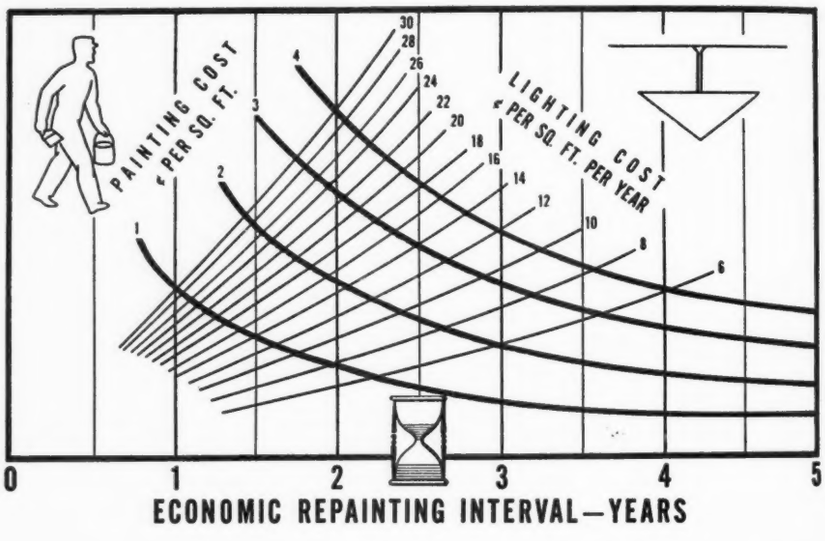
Ceilings painted white, lighting experts emphasize, give the best light reflection, but they must be kept white. Tests have shown that dirt accumulation is almost uniform from year to year over a four or five year period. Rarely will the light reduction be less than five points per year and in many cases it will be as much as ten points or more.

Costs of cleaning or repainting may be readily obtained and the light cost is a matter of brief calculation. When these factors are known, the ceiling repainting schedule may be determined from the chart.

For instance, in an organization occupying 23,000 square feet, illuminated by indirect lighting, electrical energy for one year, discounting that not used for lighting purposes, would amount to $2509 and lamp cost would be $251, a total lighting cost of $2760, or 12 cents per square foot per year. The cost of repainting the ceiling might be estimated at 2 cents per square foot.

Referring to the cost calculating chart, the line representing a lighting cost of 12 cents is followed until it meets the curve representing a painting cost of 2 cents. Dropping vertically from this intersection to the time scale reveals that for this particular set of conditions the ceiling should be repainted every 2¼ years.

To use the chart in the case of semi-indirect lighting, it is necessary only to take three fourths of the calculated lighting cost (in this example, 9 cents) and proceed with the computation as outlined above.



Following the lighting cost line on the chart above to the point at which it intersects with the painting cost line and then dropping vertically to the bottom of the chart is a quick and easy way to calculate how often a ceiling must be painted to obtain maximum amount of light reflection.

Gonadogen

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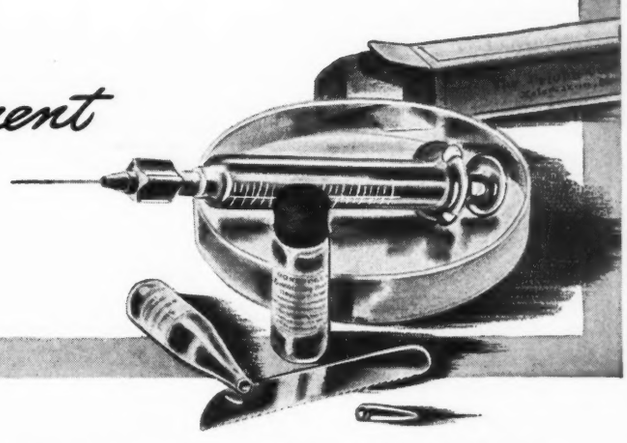

Gonadogen has aroused widespread interest because of its ability to produce gonadal stimulation in both male and female. This interesting gonadotropic hormone, isolated from the serum of pregnant mares, resembles that of the anterior pituitary in its action.

In the dry state the purified hormone maintains its potency indefinitely. Consequently it has been put up as a sterile compressed tablet and placed in a rubber-capped sterile vial. At the time of injection a fresh solution is prepared by injecting sterile water (supplied in ampoules in the package) through the rubber cap and dissolving the tablet. In this way full potency is assured.

To meet professional demands you should stock Gonadogen in its two strengths—in boxes of six rubber-capped vials, each vial containing one sterile tablet of 10 Cartland-Nelson units (approximately 200 International units), together with six 1 cc. ampoules physiologic salt solution; and in boxes of three rubber-capped vials, each vial containing one sterile tablet of 20 Cartland-Nelson units (approximately 400 International units), together with three 1 cc. ampoules physiologic salt solution.

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Trends in Kitchen Equipment

FLORENCE QUAST

Director, College Commons, Syracuse University

WELL-PLANNED and well-equipped work units contribute much to the successful operation of an institutional kitchen. Poorly planned layouts make for increased pay rolls, rapid labor turnover, food of poor quality, slow service and general inefficiency.

These work units should be as efficiently planned as a modern factory to receive raw materials, to store them if necessary, to convert them into ready-to-serve articles, to provide for service, to care for or to dispose of leftovers and waste and to permit all parts to be kept clean and in good working order.

We may expect that labor problems will increase and, therefore, future plans must consider both labor saving and provision of better working conditions for employes. There is a demand for a better quality of food, attractively served and with the nutritive elements conserved.

All these points should be considered in planning new layouts or in making changes in an existing building. The increased use of noncorrosive metals and aluminum in the defense program may affect the extent of improvements that can be made at present, but improvements are possible in any establishment no matter how old it is or how little money there is available for changes. Many improvements may be made through reorganization of present units and through inexpensive purchases.

In planning a new layout, an administrative dietitian should work with the architects and the engineer. The dietitian consulted should be familiar with food layouts of the size and requirements of the one being considered. A person familiar with commercial food service may have little conception of the requirements of a hospital kitchen. One who has worked only in small institutions may not realize the necessity for providing wide service aisles for trucking foodstuffs and for the movement of employes.

The dietitian should spend many hours studying the floor plans and layout. If alterations are to be made, she may receive valuable suggestions from employes. She should consider her employes at work to determine the type of equipment needed, the most efficient placement and possible future needs. Once installed, the equipment is a record of her wise or unwise decisions.

In newer layouts the problem of receiving foodstuffs and supplies and of disposing of garbage and refuse has been given special attention. It is an advantage to have an unloading platform so that trucks can back up to the building entrance. The unloading of heavy supplies and equipment is facilitated and accidents to workmen are reduced in number.

Scales for weighing in supplies and a shelf or desk for the storeroom man will be needed in this area. Space should be provided for elevators and for storing trucks to carry cases of canned goods or crates of produce to storerooms and preparation rooms. If the laundry is done by an outside firm, space should be provided for storing soiled laundry and a truck for receiving clean linen.

The room for garbage storage should be refrigerated, ventilated and provided with a floor drain and with an interior wall finish of tile or cement so that it can be hosed. A room for cleaning garbage cans should possess a floor steam outlet so that clean cans can be sterilized

Steam tables in the modern cafeteria are constructed of stainless metal and have accommodations for both hot and cold units. This unit and the electric stove shown are in Jefferson Hospital's cafeteria, Birmingham, Ala.

by being turned upside down over it. There must be storage bins if refuse is to be removed and an incinerator if it is to be burned.

A central janitors' supply and work room is a convenience. Reserve cleaning equipment and supplies may be stored there, preferably under lock and key. It is wise to have slop sinks for emptying mop water; equipment for washing and drying brush brooms, mops and sponges, and space to scrub, hose and dry floor mats. If liquid soap is to be made there should be a gas plate.

In this room also there might be a bulletin board with cleaning schedules and work manuals. A small workshop where a handy employe can make minor repairs to equipment and sharpen knives is a convenience. Space should be planned somewhere for storing folding tables, chairs and little used or emergency equipment.

Employes' Rest Rooms Essential

The modern floor plan provides adequate facilities for rest and cleanliness for employes with space for couches, comfortable chairs, good light for reading and separate locker rooms with mirrors, showers and toilet facilities. When employes work on split shifts it is specially important that facilities for rest and recreation be provided near their work. Scientific management recommends short rest periods during the day.

The tendency is to have each working unit complete with its own tables, machines, refrigeration and space for storing small equipment and supplies, including cleaning equipment. Each work area should have hand basins with cabinets for paper towels above.

Great progress has been made in air conditioning, ventilation, lighting and acoustical treatment. Lights of the correct intensity should be installed in the kitchens and provision made for additional light over the work units. Light fixtures should be attractive in appearance and easily kept clean and repaired. Good ventilation is essential. Hoods should be provided over stoves, steamers, broilers and dishwashers, with motors to draw off the odors.

Public interest in sanitation has been stimulated by the increasing use of noncorrosive metals and in the improved technics of fabrication. Equipment is planned with rounded corners and a minimum of ledges and panels in and under which food and dirt can lodge. Sinks are made with seamless welding and a minimum of understructure. Doors slide in a slotted channel which permits easy cleaning. Pots and pan racks are suspended from the ceiling and hoods over ranges and steamers are of the drop ceiling type so that dust cannot collect.

The dietitian should present to the architect and the engineer the problem of keeping floor and walls clean around the many plumbing pipes and table legs. Buildings of the future may be constructed with walls of the cantilever type in which steel angle-shaped plates extend under the floor and up the walls so that sinks and some work tables and equipment can be bolted to the walls with a minimum of legs. Sinks are now installed with the backs braced and bolted to the walls so that the number of necessary legs is reduced.

Water, steam, waste and gas pipes can in some cases be grouped so that all enter the floor in one spot. Stoves, refrigerators and cleaning cupboards are mounted on solid foundations with toe space provided. Care must be taken that the intake of air from the base of gas bake ovens is not diminished in volume.

Floor Drainage Important

Special floor treatment with adequate drains is provided under stock pots and steam-jacketed kettles. The problem of water splashing when these are drained should be given special study. New stock pots are enclosed so that the battery of pots looks as if it were set into a cabinet. Doors open in front for cleaning.

The perfect floor for institution kitchens is still to be discovered. Resilience is sacrificed for ease of cleaning and durability. Small, easily handled and easily cleaned mats can be used over the hard floors to lessen fatigue and employes can be encouraged to wear rubber heels.

The floor must withstand constant traffic, deterioration from heat, moisture, grease and light and the weight of heavy equipment. For ease of cleaning, floors are laid with a cove base. In dining rooms, the attractive appearance of composition tile floors may justify the increased cost of upkeep.

The food on cafeteria counters is protected by heavy glass enclosed shelves. Display shelves for salads and desserts are also of heavy glass supported by stainless metal brackets of the cantilever type. These units have a minimum of metal work, which makes cleaning easy.

Steam Tables Are Versatile

The new type of construction for steam tables permits setting up the counter to display the food to the best advantage and takes care of any change of menu. This steam table is of the open bain marie type, into which is fitted a series of removable stainless metal panels. A number of these panels are cut to receive full entree pans, half pans, round soup, vegetable and gravy units. Others are solid panels. Extra panels are stored underneath the counter in tiers on angle slides of stainless metal.

The steam table may be made in two or three separate sections and one section may be converted into a flat surface through using the solid panels. This provides space for toasters and grills for breakfast or luncheon service, or in the summer one section may be converted into a cold pan by filling it with chopped ice. If the tables are planned for this dual service, proper insulation is necessary. This provides the extra refrigerated space desirable in hot weather.

Lowering apparatus built into the counter can be used to handle trays, silverware, saucers and plates. The chassis is built in with the counter framework and it is loaded from the top. By means of calibrated springs the articles are raised automatically so that the upmost one is always ready to be picked up. The wells are insulated and heated or chilled. This arrangement permits a streamlined counter top, eliminates stooping and, in the case of the silver dispenser, is more sanitary.

Special consideration should be given to dispensing cold food, such as salads. For counter or cafeteria service, refrigerators built to receive trays of prepared salads are planned underneath the salad cold pan. In this way, salads are held in proper condition and are available for rapid counter replenishment. The same type of construction can be used to

store trays of butter chips and desserts.

Thermostats control the temperature of the wash tanks on dishwashing machines and are recommended for use on coffee urns and steam tables. If the urns and steam tables are to be heated by steam a careful survey of the steam supply should be made before installing thermostats. Steam will contain some impurities, which collect in the delicately adjusted thermostats; the correct steam pressure is important for successful operation. The construction and metals used in fabrication are also important. As yet they have not been entirely satisfactory.

Insulation Is Necessary

Alternating hot and cold units on a serving counter provide for efficient and attractive service but present problems in installation. Proper insulation is a necessity. The ordinary amount advocated by equipment engineers for insulating refrigerated salad, dessert and beverage pans is usually inadequate. Space around such equipment should be packed with extra insulating material inserted between moisture-proof partitions. Specifications for counter tops should specify that breaker strips of a molded insulation material be inserted around heated units to prevent the conduction of heat along the metal surface.

All plumbing pipes should enter through the floor directly under the point of connection. Unless steam, refrigerator, hot water, cold water and waste lines are properly placed and insulated there will be condensation of moisture. Shut-off valves for refrigeration in any unit can be collect ice and the resulting moisture causes trouble.

Dietitians might well check with the building engineer the plumbing facilities provided and the size and location of waste lines and grease traps. Refrigerator installation should also be checked to be sure that provision has been made so that the refrigeration in any unit can be turned off independently of the rest of the system.

Machines and mechanical devices should be used wherever possible to save labor and to standardize methods of preparation. Each piece of equipment should be studied as to its mechanical construction, efficiency of operation and labor in cleaning it and in keeping it in repair. There should be a storage space provided for each piece of movable equipment and parts. Each worker should have close at hand the machines and tools needed for efficient work.

Much labor can be saved by the use of movable tables and of three-wheeled dollies for trucking and for placing under large food containers. Racks constructed to hold tiers of trays and mounted on casters are convenient for storing pans of salad material and trays of setup salads or panned meats. This permits preparation in spare time. The racks are rolled into refrigerators until service time.

The racks also are useful for removing trays of prepared food from ovens and for setting up and clearing counters and steam tables. The size of these trucks should be standardized for efficient storage.

Another labor saver is the use of wire racks for washing and storing cups and glasses. The dishes are loaded into the rack, sent through the machine, air-dried, placed on a portable truck, wheeled to the counter and placed in self-leveling wells of the lowering apparatus built into the counter. This method reduces dish breakage as well as labor. Serving trays after washing are also placed on a truck and stored on the counter in the lowering apparatus.

Efficient floor plans will facilitate the transfer of prepared food to the service units but the right kind of equipment also is important. There should be adequate facilities for delivering food to the patients or patrons in the best possible condition and with a minimum of waste in food, quality and labor.

The trend is to cook food in small amounts and to keep sending it to service kitchens or steam tables so that there is a continuous flow of freshly prepared foods. To facilitate this on the steam table, electrically heated storage units are installed under the serving counter or in cabinets just back of the counter. It is well to keep these units small so that cooks will not be tempted to hold food there for too long a time.

The easiest way to provide palatable green vegetables is to cook them in a steam cooker provided with flowing steam. This method uses considerable steam but preserves the color, minerals and vitamins better than cooking by any other method. Vegetables can be placed in the steamer in the steam table pans. This prevents breaking and mashing but requires a good stock of pans. If the gauge and quality of the pan are right it will not buckle in the cooking process.

Other foods are baked and fried in small amounts as needed. The quality of meats and number of servings are controlled by inserting meat thermometers in the roasts and by cooking in thermostatically controlled ovens. The oven thermostats are set at 300° F. and the meat is roasted until the inserted thermometer registers the amount of doneness desired.

In some large institutions tough cuts of meat, such as pot roasts, are cooked in steam-jacketed kettles; in smaller places they can be cooked in large Dutch ovens placed in roasting ovens, again with the oven thermostat set to control the temperature of the oven. Either method eliminates danger of burning and the chef can forget the roast until time to take it from the kettle or oven. Also, waste from shrinkage in cooking is minimized.

Mechanical Controls for Baking

Through the use of thermostatically equipped bake ovens the volume and quality of baked goods are controlled. Ovens are often purchased in units with separate thermostats for each two ovens, allowing greater flexibility in that products requiring different temperatures can be cooked at the same time. Recipes are standardized to permit use of mechanical mixers. Speeds, number of minutes of mixing and volume to be obtained are indicated on the recipe. Along with this go standardized scoops and weights to ensure the correct yield from each product.

The progressive dietitian should constantly study the floor plans and the arrangement of her equipment for possible improvements. To those operating on a limited budget it may only be possible to rearrange existing equipment. In every system, however, one should plan for future expansion. The dietitian will derive personal satisfaction from seeing her plans take form and will realize the pleasure of accomplishment when all is completed.

"To yield to remedies is half the cure"

—SENECA

It also seems proper to say—to yield to the prescribed diet promotes the cure.

Patients welcome Dole Pineapple Juice. It has a pleasing, refreshing flavor that old and young like. Its quality is always uniform. It is the true, undiluted juice of perfect pineapples ripened on the plant in Hawaii.

Dole Pineapple Juice is a good source of Vitamins C and B-1—and contains some Vitamin A—also Iron, Calcium and Phosphorus. There are 16.9 calories per ounce. It is high in quickly available food energy and yields alkaline mineral residues in the body.

The convenience of Dole Pineapple Juice is a point that should not be overlooked. Just open the chilled can—pour and serve.

One six-ounce glass of Dole Pineapple Juice contains:

Biological Assay for Vitamins

Vitamin A	117 I. U.
Vitamin B-1 (Thiamine)	100 I. U.
Vitamin B-2 (Riboflavin)	37.2 micrograms
Vitamin C (Ascorbic acid)	240 I. U.

Mineral Analysis

Potassium	0.282 gram
Sodium	0.00228 gram
Calcium	0.0252 gram
Magnesium	0.0234 gram
Iron	0.00036 gram
Manganese	0.0012 gram
Copper	0.00006 gram
Phosphorus	0.0144 gram

Typical Analysis

Moisture (by drying)	84.7%
Protein (N x 6.25)	0.3
Fat (Ether extract)	trace
Crude Fiber	0.1
Titratable Acidity (an anhydrous citric)	0.6
Ash	0.3
Total carbohydrates other than crude fiber and acid by difference	14.0

DOLE Pineapple Juice

FROM HAWAII U. S. A.

Hawaiian Pineapple Co., Ltd. 215 Market St. San Francisco, Calif.

Warm Weather Foods

HOW often we watch both the sick and the well gaze disinterestedly at the food that is placed before them in warm weather and remark, "It's just too hot to eat." Yet, is it the weather which destroys their appetites as much as the type of food that is served them and the manner in which it is dressed? There is just as great variance in the character and dress of food we eat during the warm weather season as there is in the clothes we wear.

With the first days of spring, there is a tendency to refuse the heavy dishes we enjoyed so much in the cold weather in favor of the lighter, greener foods. Fewer starches, of course, and more fresh fruits and vegetables are the rule, and what a relief it is to have a greater variety of fresh food stuffs to draw from in planning summer menus.

Surely, patients and personnel, too, must be as tired of winter vegetables and fruits as is the dietitian. Now come fresh berries and also the tender stalks of young rhubarb, stewed or made into pies. Asparagus, that aristocrat of vegetables, is now within the realm of the most modest budget; fresh green peas are a welcome change. It's the dietitian's heyday with a wide assortment of foods to select from at prices too good to be true.

Meats for Summer

Meats assume a summer aspect, too. The smoking hot roasts that looked so appetizing a few months ago have lost their appeal. Pork, which delighted the employes during the cold weather, is now distinctly taboo. But it still appears on the menu in the guise of grilled ham or as one of a variety of cold cuts. Summer is, unquestionably, the season for grilled meats.

The same applies to drinks. Nothing is more comforting when the chilly winds do blow than a cup of hot coffee or tea. Always popular, these two beverages now appear dressed for the summer, served cold in high, crystal glasses over chunks of sparkling ice with a bit of mint tucked in at the last moment for flavor as well as color. Buttermilk, which enjoys some friends the year round, wins many more during the summer period. As its consumption increases, the popularity of sweet milk wanes. The dietitian of a southern hospital reports that when it is very hot practically no sweet milk is consumed in the dining room. Buttermilk far surpasses it in popularity and iced tea just won't stay in the pitcher.

Cold dishes have their place on the menu, served with discretion, with a hot soup or a hot beverage for balance. One dietitian adds a hot muffin or tea biscuit for good measure. This is tough on the bakery, perhaps, with the thermometer steadily rising, but is sure to make a hit with the patients.

Cold Supper Menus

Two cold supper menus a week accompanied by a hot soup are the rule in a hospital on the Pacific Coast. "The majority of the employes and patients, too, prefer hot meals," this dietitian states. "Of cold meals served they prefer meat salads, cold meat plates or sandwiches with salads. With either of these combinations we serve a hot soup, and fruit for dessert. One of our favorite main dish salads is molded egg."

Two salads a day throughout the year are the policy in this institution. In hospitals generally more salads are served in summer; fruits and vegetables are particularly popular as the main ingredients. Here is a surefire success described by another dietitian—cranberry salad in which the berries are mixed with nuts and celery.

While still on the subject of cold dishes, the observations of a southern dietitian are significant. "Nurses are fond of sandwiches and salads. Doctors do not like sandwiches, although they will accept them occasionally. One group likes salads although others ask not to have them served. In other words, we find it much easier to please the women."

One hospital serves hot dishes twice a week. It suggests: Italian spaghetti, chicken and noodles, baked beans, chicken or vegetable loaf, cheese fondue fritters, creamed chicken or chipped beef or sweetbreads. Every other week on the menu of the same hospital a seafood dish is the entree. Chop suey is served occasionally and "weenies and sauerkraut" go well with the employes.

So much for the food itself. Some attention should be given to its dress for, as everyone knows, the attractive looking dish is the one that appeals to the appetite no matter in which direction the thermometer may be heading. In her choice of garnishings as well as food, the dietitian has far greater opportunity to reveal her skill and ingenuity when the markets are well stocked with fresh produce.

If salads fail to win friends, possibly it is because they have no eye appeal. Variety in the color of ingredients or in the garnishings may do the trick. Better yet, try them on a green glass plate and watch the results.

Particularly important is the first impression the patient gets of the tray as it is brought into the room. One look and he is sold "for" or "against."

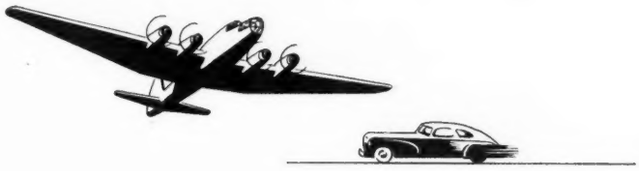
Tray Accessories

To have good looking trays is the ambition of dietitians every day in the year, irrespective of the weather. Dress and tray covers do not change radically except on such rare occasions as a holiday when for variety paper covers may be used, gaily decorated to create the atmosphere of a party. Linen for private patients is preferred. Some hospitals use colors —pale green and yellow, for example—while others stick to the more conservative white.

"We use paper napkins and tray covers occasionally, when the supply of linen is low," a dietitian said the other day, "and always have complaints about them. However, these complaints usually come from chronic grumblers, often members of our own staff."

Too hot to eat? Maybe. But who will deny that the right food served in the right way will go far toward making the most sensitive patient think less about the weather and more of an attractive tray with just the right foods for a hot summer day.

. . . Do you realize how far *Electric Cooking* has come in the last 10 years?



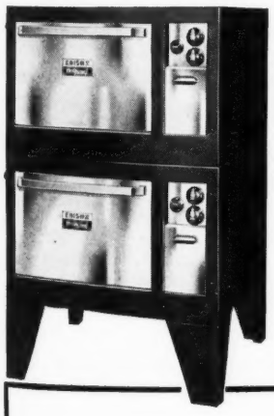
It doesn't seem so long ago. Yet, in 1931 there were no lightweight trains, no stratosphere airliners, no streamlined automobiles. The difference between your old cooking equipment and modern time-and-money-saving electric equipment may be just as great!

YOU can take it for granted that, whatever reliable cooking equipment you buy today, you will get far more value for your money than ever before. But do you realize how *much more* you *should* get?

Today's good electric cooking or baking equipment is as far advanced in its design and efficiency beyond old methods as your 1941 automobile is ahead of the one you drove ten years ago. Often the savings made by efficient operation of modern equipment actually *pays off the investment* in a few short months, to say nothing of the added convenience you enjoy.

Because you may happen to be familiar with a certain make of equipment is no reason to install the same equipment when the old needs to be replaced. Now, *before you make an investment*, learn what science has done to develop the art of electric cooking. The chances are, you will be surprised how far we've come in the last ten years.

You will learn that Edison-Hotpoint Electric Equipment is now standard in places where accuracy, cleanliness, comfort and convenience are prime requirements. That is because Hotpoint has *pioneered* the big money-saving improvements in electric cooking and baking equipment. Before you buy, investigate how much you will save by installing modern economical Edison-Hotpoint Electric Equipment!



EDISON-HOTPOINT'S NEW "CHAMP" ELECTRIC RANGE

This heavy duty 3-foot sectional type range offers these new features: 1. Top surface units available in wide variety. 2. Convenient, large capacity grease trough. 3. Calrod Heating Elements. 4. Sectional top and oven sections available separately.

Edison Hotpoint's "Husky" All-Purpose Oven provides fast, rugged, automatic service for a wide variety of oven cooking jobs such as braising, oven frying, scalloping and au gratin work. Fast—heats to 500° F. in 25 minutes. Edison General Electric Appliance Co., Inc., 5662 West Taylor Street, Chicago, Illinois.

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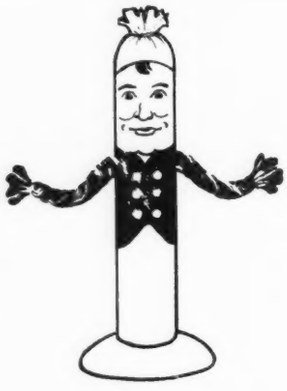
HOLIDAY TRAY DECORATIONS

Suggested by New Jersey Dietetic Association

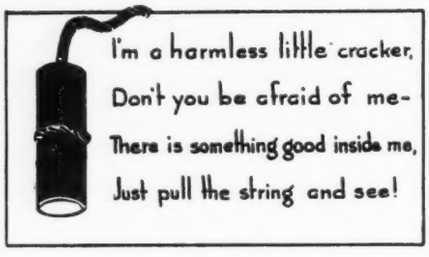
Left: To fashion this favor, take an 8 inch square of red cellophane and a bit of blue ribbon, 9 inches long and ⅛ inch wide. The little flag is of silk mounted on a pole, 3½ inches long. Fill with mints for the patients' trays.

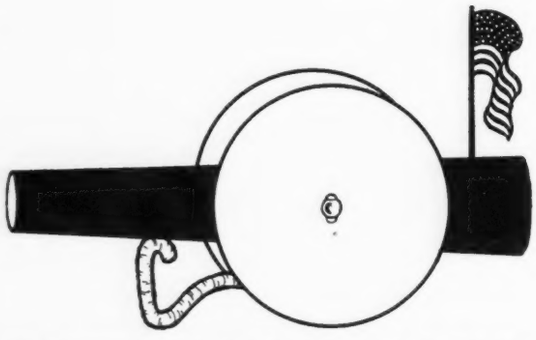


Right: The peppermint man is made of red and white stick candy. His face is painted on white paper. The candy is wrapped in colorless cellophane; coat and arms are of red cellophane. The gentleman stands upon a 1½ inch button base.

Left: White pipe cleaners form the body, arms and legs of this figure, which is 4 inches tall. The head is of cheesecloth stuffed with cotton, with facial features painted on it. Yellow yarn forms the hair, sewed on in loops and clipped. He wears a red yarn tie. The blue percale trousers are stitched with white thread, and the suspenders are made of blue yarn. The base is formed of a square of white paper.

Right: Here is a menu holder. On a rectangle of cardboard, 3 by 4 inches, is mounted a firecracker made of a roll of red drawing paper tied on with red thread. The menu, inscribed on white paper, is inserted into the firecracker.





The barrel of the cannon, 3 inches long, is made of red drawing paper. Wheels, 1¾ inches in diameter, are of blue drawing paper fastened on with beads. A white pipe cleaner serves as a support. Add a small silk flag.

FOOD FOR THOUGHT

• There is no limit to the number of helpings served young patients on the wards of Children's Memorial Hospital, Chicago, Mabel W. Binner reports. No food is forced upon a child and there is sufficient choice at every meal so that a well-balanced diet can be selected without cramming down some food that the youngsters thoroughly dislike.

Hamburgers and hot dogs are favorites. Plain food is preferred to dishes that are mixed together, creamed or dressed up. Six and seven helpings are not unusual. There is one boy patient on record who ate 16 slices of toast for breakfast!

• The big ice cream season lies immediately ahead. Mary Edna Golder, dietitian at St. Anne's Hospital, Chicago, varies the ice cream served there by adding one of the following flavors: persimmon, rum and raisin, grapenut, coffee, date, honey, pumpkin, ginger, coconut custard, eggnog, peanut brittle and sweet potato.

• Business is the best place for men—it needs men—and hospitals, because of their economic constitution, will always remain a place more suitable for women who are trained dietitians, says Charles P. Alcorn, assistant supervising dietitian, St. Luke's Hospital, New York.

Men could be a definite asset to the hospital quantity foods field because of their natural advantages in the management of male personnel and their mechanical and technical sense, but this phase of foods work will probably never attract many trained men, Mr. Alcorn believes.

Women have so completely dominated the hospital field that women's working conditions and salary standards exist. Men can function only in the quantity foods kitchen where the personnel is chiefly men; therapeutic work is definitely not remunerative enough for a man.

Salary limitations are too low in hospital foods for the ambitious man, Mr. Alcorn asserts. The average monthly salary for the quantity food production dietitian is $150 or less. The supervising dietitian usually earns more, but men would rarely, if ever, be considered for these supervisory positions because of the female personnel on the dietary staff. Thus $150 per month would be the average salary offered to men who have spent $3000 or $4000 securing an education sufficient to manage the quantity foods kitchen. To the major portion of the male contingent, this would be inadequate.

ONE OF THE *Biggest Little Things* IN MODERN NUTRITION

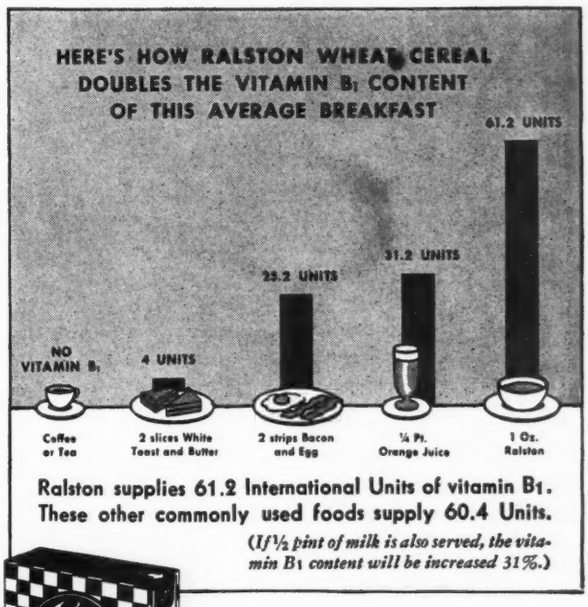
The tiny wheat germ, one of Nature's richest sources of vitamin B_1, is one of the biggest little things in helping to protect against vitamin B_1 (thiamin) subnutrition in modern diets.

Take breakfast, for example. The accompanying chart shows how Ralston, enriched with natural wheat germ, doubles the vitamin B_1 content of the average breakfast. Each ounce serving supplies 61.2 International Units of vitamin B_1—considerably more than whole wheat itself, much more than most other wheat cereals.

For this reason many hospital dietitians specify Ralston regularly—depend on this delicious hot cereal to help increase vitamin B_1 content in patient and staff diets.

Purchasing agents and superintendents welcome its use also because Ralston is economical—three servings cost only a penny—and it is easy to prepare, cooks completely in 5 minutes.

FREE TO HOSPITALS: New illustrated 20-page bound book, "Whole Wheat and Its Importance as a Source of Natural Vitamin B_1," and generous supply of samples sent free on request. Send name, title and hospital. Address Ralston Purina Company, 939E Checkerboard Square, St. Louis, Mo. (Offer limited to United States.)


HERE'S HOW RALSTON WHEAT CEREAL DOUBLES THE VITAMIN B_1 CONTENT OF THIS AVERAGE BREAKFAST
61.2 UNITS
31.2 UNITS
23.2 UNITS
4 UNITS
NO VITAMIN B_1
Coffee or Tea
2 slices White Toast and Butter
2 strips Bacon and Egg
¼ Pt. Orange Juice
1 Oz. Ralston

Ralston supplies 61.2 International Units of vitamin B_1. These other commonly used foods supply 60.4 Units.

(If ½ pint of milk is also served, the vitamin B_1 content will be increased 31%.)

Ralston

puts the B_1 in Breakfast

July Dinner Menus for the Small Hospital

A. Sternlicht

Dietitian, Municipal Hospital, Beloit, Wis.

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Tomato Bouillon	City Chicken Legs	New Potatoes Butter Sauce	Asparagus Tips	Mixed Vegetable Salad	Spanish Cream, Lady Fingers
2.	Two Tone Cocktail	Roast Beef	Pan Browned Potatoes With Gravy	Julienne Carrots	Stuffed Celery Salad	Fresh Peach Cobbler
3.	Jellied Consommé	Lamb Chops	Potato Puff	French Wax Beans	Pineapple-Cherry Salad	Date Torte, Whipped Cream
4.	Vegetable Soup	Baked Perch	Escalloped Potatoes	Pickled Beets	Carrot and Raisin Salad	Ice Cream Molds (Flags—Fourth of July)
5.	Grapefruit Juice Cocktail	Chop Suey	Rice	Spiced Seckel Pear Garnish	Lettuce and Tomato Salad	Lemon Chiffon Pie
6.	Fresh Fruit Cocktail	Roast Chicken	Baked Potato on Half Shell	Buttered Peas	Celery and Olives	Maple Nut Ice Cream
7.	Cherry Nectar	Swiss Steak	Mashed Potatoes	Cauliflower, Cheese Sauce	Asparagus Salad With Pimiento Strips	Prune Whip
8.	Beef Bouillon With Noodles	Meat Loaf	Mashed Potatoes	Baked Egg Plant	Coconut, Celery and Apple Salad	Butterscotch Pudding With Nuts
9.	Onion Soup With Grated Cheese	Breaded Veal Cutlets	Riced Potatoes	Spinach Ring	Tomato Aspic	Gingerbread With Whipped Cream
10.	Tomato Juice	Beef Stew	Boiled Potatoes With Gravy	Buttered Carrots	Stuffed Green Pepper Salad	Pineapple Upside-Down Cake
11.	Assorted Canapés	Baked Pike	Creamed Potatoes	Broiled Tomatoes	Waldorf Salad	Schaum Torte With Blackberries
12.	Chicken Broth With Rice	Broiled Calves' Liver	Julienne Potatoes, Cheese Sauce	Fresh String Beans	Banana and Nut Salad	Chocolate Pudding
13.	Chilled Fruit Punch	Chicken Fricassee	Mashed Potatoes	Fresh Lima Beans	Perfection Salad	Butter Pecan Ice Cream
14.	Apple Juice Cocktail	Meat Balls, Barbecue Sauce	Parsley-Buttered Potatoes	Broccoli, Hollandaise Sauce	Grapefruit Sections, French Dressing	Bread Pudding, Vanilla Sauce
15.	Consommé Julienne	Individual T-Bone Steak, Mushrooms	Baked Potatoes	Spinach Soufflé	Hearts of Lettuce, Thousand Island Dressing	Cherry Whip
16.	Orange-Mint Cocktail	Broiled Sweetbreads on Toast	Stuffed Potatoes	Beet Greens With Vinegar	Pear and Lime Gelatin Salad	Graham Cracker Torte
17.	Clam Broth	Roast Leg of Lamb, Mint Sauce	Buttered Rice	Baked Squash	Frozen Fruit Salad	Caramel Ice Box Pudding
18.	Fruit Juice Cocktail	Whitefish, Lemon Sauce	Potatoes au Gratin	Corn	Apricot and Cheese Ball Salad	Glorified Rice
19.	Assorted Relishes	Stuffer Hamburger Loaf	New Potatoes, Butter Sauce	Carrots and Peas	Pineapple and Mandarin Salad	Jelly Roll
20.	Assorted Canapés	Broiled Chicken	Baked Potatoes	Wax Beans	Coleslaw	Apple Betty
21.	Grape Juice	Veal Steak, Tomato Sauce	Mashed Potatoes	Corn	Frosted Melon Mold	Tapioca With Sliced Peaches
22.	Fruit Juice Cocktail	Lamb Chops	Potato Puff	Creamed Mushrooms	Cardinal Salad	Cherry Cobbler
23.	Apricot Nectar	Pot Roast	Pan Browned Potatoes	Diced Beets	Combination Cream Cheese Salad	Spice Cake
24.	Melon Ball Cocktail	Mock Chicken Legs	Baked Potato on Half Shell	Cauliflower, Cheese Sauce	Celery and Olives	Charlotte Russe
25.	Tomato Juice	Broiled Halibut	Creamed Potatoes	Frosted Buttered Spinach	Cottage Cheese and Green Pepper Salad	Blueberry Tarts
26.	Two Tone Cocktail	Swiss Steak	Mashed Potatoes	Asparagus Tips	Hearts of Lettuce, French Dressing	Fruit Gelatin, Whipped Cream
27.	Chilled Honey Dew, Lemon Slices	Roast Chicken	Mashed Potatoes	Fresh String Beans	Apple and Date Ring	Sherbet With Vanilla Wafers
28.	Chopped Liver on Toasted Crackers	Lamb Stew	New Potatoes With Stew Gravy	Peas	Wilted Lettuce	Rice and Date Pudding
29.	Sauerkraut Juice	Baked Liver	Parsley-Buttered Potatoes	Creamed Celery	Stuffed Prune Salad	Snow Pudding
30.	Chicken Broth With Vermicelli	Roast Leg of Veal	Pan Browned Potatoes	Escalloped Tomatoes	Mixed Fruit Salad	Chocolate Ice Box Cake
31.	Jellied Consommé	Creamed Sweetbreads on Toast	Potato Puff	Baked Squash	Lettuce Roll	Pineapple Ambrosia

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Executive Housekeeper
St. Barnabas Hospital, Minneapolis

RELIABLE workers in the field of scientific color are trying to establish therapeutic and esthetic evaluations of color in the treatment of specific mental ailments and diseases. At St. Barnabas Hospital, Minneapolis, Minn., color work has been done chiefly with the convalescing patient in mind.

Until those who plan, manage and maintain hospitals recognize scientific color work as one of their tasks, we shall always have to contend with the negative attitude of those who say, "I hope I will never have to go to a hospital." When we stop to consider the hospital rooms of yesterday and even some of today we can scarcely blame the patient who feels he has been "condemned" when advised he must be hospitalized.

Applying paint to a room has a standard cost regardless of the color used. Surely a patient can be cared for in a room that has been painted yellow, aquamarine, coral or shell pink just as well as in a room that is the color of a prison wall, and certainly the patient's days of hospitalization will be more enjoyable.

The first step in choosing a color for a patient's room is consideration of the exposure. Whence comes the light? South and west rooms should be decorated in a cool color, such as blue green or chartreuse, with gay draperies and slip covers. The yellows, warm pinks and creams with draperies and slip covers of the solid and warm tones should be used in the decoration of the north and east rooms.

We all associate various colors with certain moods, places, contacts, things or events. We must, therefore, take into consideration the "weight of effect"* of color in the intelligent planning of its use in the patient's room. With color we can induce cheerfulness or depression; we can stimulate or excite.

Yellow stimulates without exciting.

Red stimulates and excites.

Blue is cooling but if used in too large quantities induces depression.

Green is a mental sedative.

Brown is restful.

White is cold but when combined with colors may be made cheerful.

The weight of effect of any color may be altered by lightening it (adding white) or toning it (adding black). Take as an example the primary red that is hot and stimulating. With the addition of enough white to change it to a delicate tint it becomes cool and has a "womanly" characteristic. Toning primary red makes it warm, rich and friendly. However, each of these tints and shades has its proper place and time and one could not possibly be used for the same purpose as the other. "Weight of effect" is the basis of all color planning.

We must bear in mind, also, the effect of color harmony. A pleasing color combination does not just happen; it is the result of long and serious planning. Each room presents a separate and individual problem, owing to the variables of size, shape and exposure. The problems presented can be solved only by a scientific approach. When colors are brought together in a patient's room their selection must be guided by the following classifications: (1) the complementary harmony, (2) the double complementary harmony and (3) the split complementary harmony.

Colors directly opposite each other on the color wheel are complementary harmonies. Two directly

*Goldstein: Art in Every Day Life, The MacMillan Company, New York, 1928, p. 204.

Suggested Color Schemes for Private Rooms for Women

Exposure	*Walls*	*Ceilings*	*Linoleum*	*Furniture*	*Draperies*	*Venetian Blinds*	*Bed Spreads*	*Scatter Rugs*
South	soft green with blue cast	off-cream with flesh cast	eggshell with blue-green border	bleached walnut, Swedish modern design	textured rayon, peach-pink	cream with green tapes	textured rayon, peach-pink	soft peach-rose
North	peach	light cream	eggshell with gray-green border	wood painted soft green	floral chintz in soft peach, blue, green and yellow	cream with peach tapes	peach rayon	soft green
East	soft light powder blue	light cream	eggshell and beige-tan with terra cotta border	mahogany, colonial design	chintz, simple geometric design in soft terra cotta, cream and blue	cream with light blue tapes	eggshell, corded in blue	soft blue
West	deep cream	soft green	light green with darker green border	maple with low post beds	chintz, green background with yellow, pink-orange and blue	cream with green tapes	cotton, tufted in green	tones of cream, tan and green

Prepared by Helen Barker, interior decorator, New York City, for The Hospital Yearbook.

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Suggested Color Schemes for Private Rooms for Children

Exposure	*Walls*	*Ceilings*	*Linoleum*	*Furniture*	*Draperies*	*Venetian Blinds*	*Bed Spreads*	*Scatter Rugs*
South	soft blue with frieze just below ceiling	cream	blue and eggshell with blue border	wood painted cream with pink lines	dotted swiss	cream with pink tapes	pink cotton	blue
North	soft yellow with frieze at eye level	cream	eggshell with blue border	wood painted blue	cream, piped with blue and red-orange	cream with blue tapes	cream cotton	blue
East	lower two-thirds pink, balance cream; frieze at juncture	off-white	eggshell with blue border	wood painted blue	dotted swiss	cream with blue tapes	pink cotton	blue
West	blue wainscoting up 25"; cream-white above	white	eggshell with soft red border	wood painted soft gray with red lines	soft blue, trimmed with red and white binding	cream with blue tapes	white, trimmed in red and blue	blue

Suggested Color Schemes for Private Rooms for Men

Exposure	*Walls*	*Ceilings*	*Linoleum*	*Furniture*	*Draperies*	*Venetian Blinds*	*Bed Spreads*	*Scatter Rugs*
South	neutral beige-gray	off-cream	eggshell and black with black border	bleached wood, Swedish modern design	modern textured rayon with light tan ground and stripes of yellow and two tones of burgundy	cream with light brown tapes	tailored textured burgundy rayon	burgundy
North	warm tan	cream	tan and brown with brown border	walnut, modern design	modern textured material with geometric design in yellow, brown, green and terra cotta	cream with green tapes	modern textured rayon of yellow, bound in brown	brown
East	deep cream	off-white	cream and tan with blue border	modern oak finished in wheat color	textured material with narrow horizontal stripes in blue and eggshell	cream with blue tapes	blue rayon, piped in cream and terra cotta	blue
West	light putty color	off-cream	blue-green with darker border	modern wood in London tan finish	modern textured, soft-toned plaid of tan, blue-green, yellow and copper	cream with blue-green tapes	blue-green, piped in tan	brownish copper

Tables prepared by Helen Barker, interior decorator, New York City, for The Hospital Yearbook.

neighboring colors, when used with two other directly neighboring colors, are double complementary harmonies. Combining a primary or an intermediate color with the color on either side of its complement is a split complementary harmony.

In planning colors for hospital rooms, it is advisable to use simple harmonies. Various tones of one color may be used or, perhaps, two adjacent colors. If color opposites are used, they should not be too contrasting. For instance, in a hospital room one would never use primary red and its opposite green in the same motif; a much more pleasing combination will be obtained through proper lightening or toning.

The colors used in the halls, corridors, reception rooms, dining rooms and offices, although they may never be seen by the patient, have a great influence on his welfare. The doctor and nurse, if they come to the patient from a pleasing atmosphere, will carry along with them some of that beauty. The attitude of the visitor who walks through the corridors to the patient's room may elevate or depress the patient. Yes, great care in the proper decoration of these public areas is of vital importance to the entire scheme of color.

We at St. Barnabas Hospital feel that more yellows and greens should be used throughout the hospital. These are life-giving colors and everyone responds to the sunny atmosphere they create.

Colors may be measured in terms of warm, hot, sunny warm, sunny cool, cool and cold. All colors that appear to have blue or green in them are cool. The closer green approaches blue the cooler it is; on the other hand, the closer it approaches yellow the sunnier it is.

Hospitals need not exclude any color or combination of colors; the entire field is theirs. Colors used with respect to the foregoing laws and with understanding will serve a functional as well as a decorative end. The application of color in the hospital is a new and broad study. Great progress is being made along the lines of proper color combinations. Much can be gained by those who plan, manage and maintain hospitals by following the leaders in color work and by acting on their advice whenever possible.

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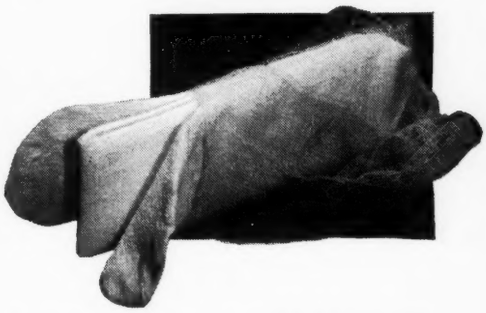

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2. *Distribution* within the pad—the highly creped sheets form capillary tubes that disperse moisture within the pad, permitting greater utilization before there is a tendency for the pad to soak thru to the outer surface.

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Equipment for Manufacturing

H. G. DeKAY
Associate Professor of Pharmacy, Purdue University

PURDUE University is fortunate in having a student health service that has a staff of four physicians, two trained nurses and a laboratory technician. The department is housed in the new administration building and is equipped with the modern electrical and medical necessities for diagnosis and treatment of disease. The students of the university pay a small fee for medical service, which includes examinations and administration as well as partial hospitalization and medication as dispensed in the apothecary shop.

The school of pharmacy has an apothecary shop where three registered pharmacists are on duty during regular school hours. The senior pharmacy students fill the prescriptions that are brought to the apothecary. The student body numbers about 6500 and the prescriptions that are filled in this department total approximately 25,000 annually.

The majority of preparations dispensed by the apothecary are made by the junior pharmacy students in the manufacturing laboratory under the direct supervision of two professors. The preparations are carefully checked before they are sent to the dispensing room.

The manufacturing laboratory is gradually increasing its mechanical equipment. During the first semester of 1940-1941, the laboratory manufactured and prepared the following amounts in five important classes of products: 100,000 capsules, 200 pounds of ointments, 1000 gallons of liquid preparations and 100,000 tablets.

The major functions of this course in manufacturing pharmacy are to prepare material for dispensing and to give the students a thorough foundation in small scale production so that they are qualified to do this type of work for hospitals, physicians and druggists. When the junior pharmacy student enrolls in this course he has had all of the necessary prerequisites for studying small scale production.

Junior and senior pharmacy students, under the direction and supervision of registered pharmacists, prepare medicines in the manufacturing laboratory and fill prescriptions in the apothecary shop at Purdue University.

It is not wise to advocate the manufacture of all types of preparations in the hospital dispensaries because many of the products require extensive chemical control, which is usually outside the realm of the dispenser. However, there are products that the hospital pharmacist can conveniently manufacture.

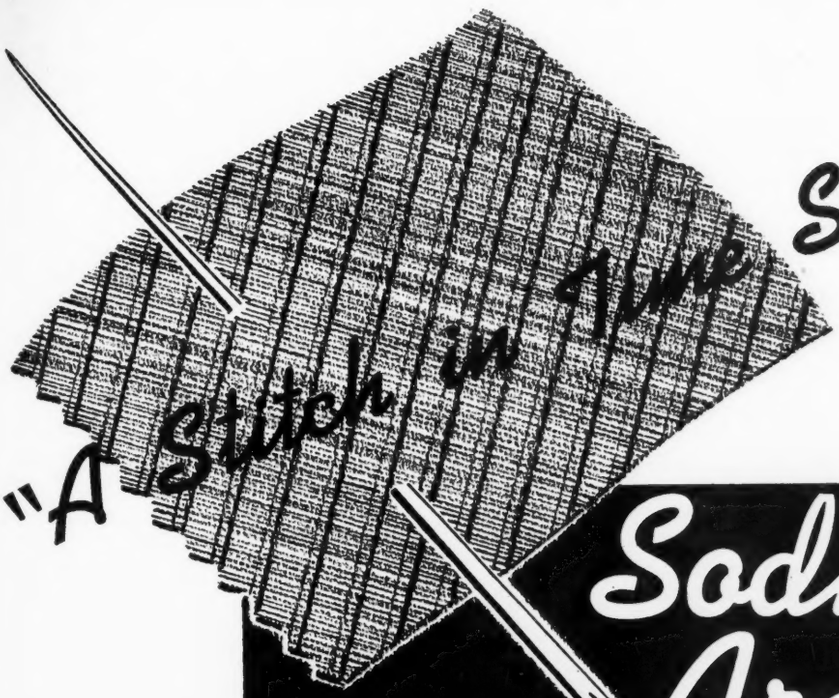
The question of actual cost of equipping a manufacturing laboratory is an important one. The cost will depend upon the kind, types and quantity of preparations to be manufactured. The accompanying table is a summary of the equipment that we have in our laboratory. The hospital pharmacy may choose from the list the pieces necessary for the work it hopes to do.

There is naturally an overlapping of equipment from one type of preparation to another. The preparations may be divided conveniently into several classes, such as capsules, collyria, elixirs, inhalants and sprays, liniments, lotions, mixtures, mouth washes, ointments and creams, powders, solutions and tablets.

A discussion of these various items may assist in planning hospital equipment.

Balances. There should be one regular prescription balance that is sensitive to 1/20 grain. This balance can be used for weighing small quantities as well as all potent chemicals, drugs and medicinals. The second balance or scale should weigh quantities in grams and ounces up to 10 pounds.

Containers. A porcelain pan of suitable capacity will be needed for heating liquids, fats and waxes. A larger pan, preferably of cast aluminum, will be needed for mixing



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batches of powder, for making masses of effervescent salts, for tablet granulation and for making large batches of ointments and creams in quantity.

Crocks and jars of suitable size, such as 4 and 10 gallon crocks for mixing purposes and 5 gallon jars or carboys for storage purposes, will be needed. Glass lined tanks make ideal mixing and storage containers and may be obtained in sizes ranging from 5 gallons up. If glass lined tanks are used for mixing purposes, a power mixer will be needed to obtain a uniform mix.

We have found that a 4 liter bottle graduated in 250 cc. units is almost indispensable for measuring larger volumes.

Filtering Equipment. Filters should be of two types: gravity and pressure. The glass funnels will answer for the gravity filters and should be of sufficient size to hold 1½ or 2 gallons of liquid at a time. Suitable wooden or iron racks can be built to support funnels during filtrations. A good pressure disk filter is useful if there are large quantities of liquids to be filtered at a time. Glass funnels will prove to be the best for use in the average hospital.

Homogenizing and Emulsifying Equipment. Our emulsifier has a capacity of approximately 1½ gallons and is hand operated. While the colloid mill is one of the most useful emulsifiers, it is usually far too expensive for the average laboratory; there are several small sized emulsifiers on the market, any of which will suffice.

Filling Equipment. A capsule filling machine is valuable in a dispensary where large quantities of capsules are filled. The machine that we are using has several disks for various sized capsules and has a capacity of 1800 capsules per hour. It requires two individuals to operate it.

Bottle filling equipment of the vacuum pump or suction pump type may be obtained for filling various sizes of bottles. However, the average hospital pharmacy will not need this equipment.

Collapsible tube filling and closing equipment will find extensive use in an apothecary shop that dispenses a variety of ointments in small containers. The hand operated, sausage stuffer type of filler is most economical for filling the tubes and the hand operated closing equipment will prove adequate unless there is a large number of tubes filled at a time.

Mixing Equipment. A kitchen mixer is one of the handiest forms of mixers in a laboratory because of its multiplicity of uses. If the hospital laboratory is to make quantities of 10 or more gallons at a time it will be necessary to have a power driven mixer. A batch mixer for larger batches of powders, effervescent salts and tablet mixtures should be provided.

Sieves are of extreme importance. They may be built of 1 by 4 inch oak having a base, 14 by 20 inches, covered with stainless metal screen. The point of contact may be covered with a ½ by 1 inch strip to prevent the wire from pulling away from its support. Sizes of the sieves will be determined by the type of material to be manufactured.

An ointment mill is a valuable piece of equipment if the laboratory uses ointments in quantity.

Percolating Equipment. The common glass percolators are valuable but should be of large size for use with quantities of 1 quart, ½ gallon and 1 gallon. If the hospital manufactures syrups, a 10 gallon tin lined copper percolator will be of great value.

Triturating Equipment. Large wedgewood mortars having a diameter of 10 inches at the top are found useful for making ointments and triturating chemicals. The small sized ball and pebble mill, having a capacity of 1 gallon, is of value in the hospital that makes color powders or mixtures.

Tablet Equipment. The equipment used for tablet manufacture will consist of mortars and pestles, pans, powder mixing equipment, sieves for granulations and compressing machines. The tablet machine may be a table or floor model, hand or power driven.

It is difficult to outline a definite plan of equipment for any hospital until a number of pertinent questions have been answered. These questions will involve details, such as size of pharmacy, size of hospital and types of products to be manufactured.

Equipment Used by Students at Purdue Manufacturing Laboratory

Apparatus marked by asterisk (*) should be found in every laboratory for small scale production

BALANCES
*A good prescription balance
*Scale weighing in grams, ounces and pounds

CONTAINERS
*Pans
Porcelain of 10 quart capacity
Cast aluminum of 40 to 50 quart capacity
*Crocks and jars
4 gal.
10 gal.
5 gal.
Tanks
20 gal. glass lined mixing tanks

FILTERING EQUIPMENT
*Funnels
12 inch glass funnels, 1½ gal.
8 inch glass funnels, ½ gal.
*Funnel racks
Multiple-disk filter

EMULSIFYING AND HOMOGENIZING EQUIPMENT
*Emulsifier
*Hand homogenizer
Large scale homogenizer

FILLING EQUIPMENT
Capsule filling machine with disks
Bottle filling apparatus
Collapsible tube filling equipment
Collapsible tube closing equipment

MIXING EQUIPMENT
*High speed electric mixers
*Kitchen mixer
*"Lightning" mixer
*Batch mixer
*"Pony" mixer
*Sieves of stainless metal
Sizes 8, 12, 16, 20, 60 mesh

OINTMENT MILL
With stainless steel cutting edges

PERCOLATING EQUIPMENT
*Glass percolators, ¼ gal., ½ gal. and 1 gal.
Copper percolators, tin lined, 10 gal.

TRITURATING EQUIPMENT
*Large mortars and pestles, 10 inch
Ball and pebble mill, 1 gal.

TABLET EQUIPMENT
Coating and polishing pans
Hand operated tablet machine
Power operated tablet machine

MISCELLANEOUS
*Dippers and pitchers for pouring liquids
*Graduates measuring minims to 2000 cc.
*Electric hot plates
*Normal apparatus found in the dispensing apothecary shop

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EVEN fiction holds no more dramatic episode than the first public demonstration of surgery with ether in the Massachusetts General Hospital on October 16, 1846. Turning to the hitherto incredulous audience, the surgeon pointed to the quiet, anesthetized patient and proclaimed, "Gentlemen, this is no humbug!"

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NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, MD., Arnold J. Lehman, M.D., and Harold Chase, M.D., Wayne University, Detroit

Factors Producing Nasal Symptoms

Lillie has said: "A well-functioning nose may not be a thing of beauty, but it is a joy forever."

Emphasis has recently been placed, particularly by the Mayo Clinic group, upon the production of nasal symptoms by normally functioning physiologic processes and by exaggerated physiologic responses actuated by ill-advised medications.

A comprehension of the character of the nasal respiratory membrane is essential to an understanding of the genesis of these symptoms. It is composed of cavernous blood spaces, of erectile tissues closely related in morphology and function to the erectile tissues of the genital organs.

These tissues usually reach the height of functional activity after puberty and begin atrophic changes in the third decade. They are distributed mainly over the turbinates and have for their primary functioning the "conditioning" of the inspired air which they moisten and warm as it passes over them.

Vasodilation causes discharge of serum into the glands and swelling of the stroma. Networks of capillaries about the mouths of the glands act like purse strings to retain the secretions in bulging glandular pockets. Upon vasoconstriction these glandular contents are released and expressed by the elastic tissues, flushing the mucosa with a seromucous fluid, which is bacteriostatic in its action. One pint to 2 quarts of fluid is thus exuded in twenty-four hours.

There is a definite cycle of filling and emptying in which the two nasal passages work in alternating relationship. Owing to the swelling of the mucosa, the air route alternates every one half to two hours, varying with the individual. This periodic obstruction may lead to the often mistaken self-diagnosis of sinus disease.

Complaints of obstruction on the dependent side on awakening in the morning, associated with dryness of the mouth, headache and "pus" in the throat, are due to the gravitation of fluid into the mucosa of the dependent side and to the cessation of normal swallowing reflexes during sleep. These reflexes, when active, would remove the seromucous discharge. Such symptoms often lead the individual to spend ridiculously long periods of time each morning gargling and using vasoconstrictive nose drops in an attempt to free the air passages and to get rid of the "pus," when "one clearing and two swallows" might suffice. In the absence of anatomical defect, humidifying the air and raising the head and shoulders on two to three pillows during sleep may alleviate the condition.

Conversely, with the aging of this tissue atrophic changes occur, giving rise to a dry hacking cough originating reflexly from an area of drying and inflammation. Accumulation of crusted material in these areas may occur. This condition responds to intranasal medication with estrogens in the female and with testosterone in the male.

Persons whose occupations expose them to abnormally rapid changes in climatic environment, such as farmers, oil station attendants and delivery men, especially if they are of adolescent age, may complain of stuffy runny noses and of a tendency for postnasal discharge. The rapid functional alteration of the state of respiratory membrane following abrupt changes of climatic environment tends to cause hypertrophy. Here the use of nasal vasoconstrictors or other medication can do nothing but harm to an already overstimulated organ. The only recourse is to change occupation or to endure it.

Another phase of activity of the respiratory mucosa that must be considered especially in its physiologic relationship to drug therapy is that of action of therapeutic agents upon the cilia. The mucus and the cilia act as barriers to infection. Any therapeutic measure that interferes with the normal wave-like beating of the cilia provides a likely entryway for infection.

The pathway of ciliary motion leads from the small chambers of the nose to the large ones. Normally, mucus is transported in thirty minutes from the most remote parts of the nose to the pharynx from which the swallowing reflexes pass it on into the esophagus.

Cilia are not resistant to cocaine solutions stronger than 5 per cent, epinephrine stronger than 1/10,000 or benzedrine in solutions of 1 to 3 per cent. Under the action of these strengths of the vasoconstrictive drugs the ciliary action slows and stops, usually beyond the point of resuscitation.

Proetz and others have found that other vasoconstrictors, namely 1 per cent ephedrine, benzedrine as an inhalant (with oil of lavender) and neosynephrin hydrochloride, are not as detrimental to ciliary action and can be used with comparative impunity. Fortunately, also, cilia tend to recover following surgical trauma.

One phenomenon relating to nasal therapy for which physiologic explanation is not yet adequate is "nose to lung conduction," or the tendency for oily medications from the nose to be aspirated into the lungs. Such aspiration results in lipoid pneumonia from the chemical activity of the absorbed oils.

Mineral oil has been incriminated as a vehicle commonly used in nasal therapeutic preparations which, especially in chronic users, is most likely to be aspirated and to produce lipoid pneumonia. Walsh and Cannon have discussed this subject recently. One elderly patient who used oily preparations to soothe his dry, irritable atrophic membranes nightly for three years was found at postmortem examination to have typical lipoid pneumonia.

Oily substances are not the only medicaments capable of producing pulmonary damage. It has been demonstrated that water solutions of silver proteins, *i.e.* neosilvol, when aspirated, may cause the formation of edema and focal necrosis. They are such weak bacteriostatic agents that infectious organisms aspirated at the same time may act on the chemically damaged pulmonary tissue causing purulent bronchitis and bronchial pneumonia.

Drugs of sympathetic action often produce results quite the opposite of those that one would expect from their pharmacologic nature. Instead of anticipated vasoconstriction and freeing of air passageways, vasodilatation with nasal congestion may occur either primarily or secondarily. The mechanism of action of these agents appears to be by means of some effector substance at the sympathetic nerve endings.

When this material becomes exhausted through too strong, too frequent or too prolonged administration of the vasoconstrictors, a secondary and refractory relaxation occurs. In this state the drug has less and less effect and nasal congestion becomes more marked. Chronic congestion of the nasal mucosa is produced in persons habituated to the use of vasoconstrictor medication for several months.

We have attempted to point out some of the limitations of commonly used nasal medications and some conditions which are productive of annoying symptoms but which are dependent upon normal physiologic reactions. The latter conditions respond better to physiologic acceptance or readjustment than to attempts at symptomatic treatment.—Harold F. Chase, M.D.

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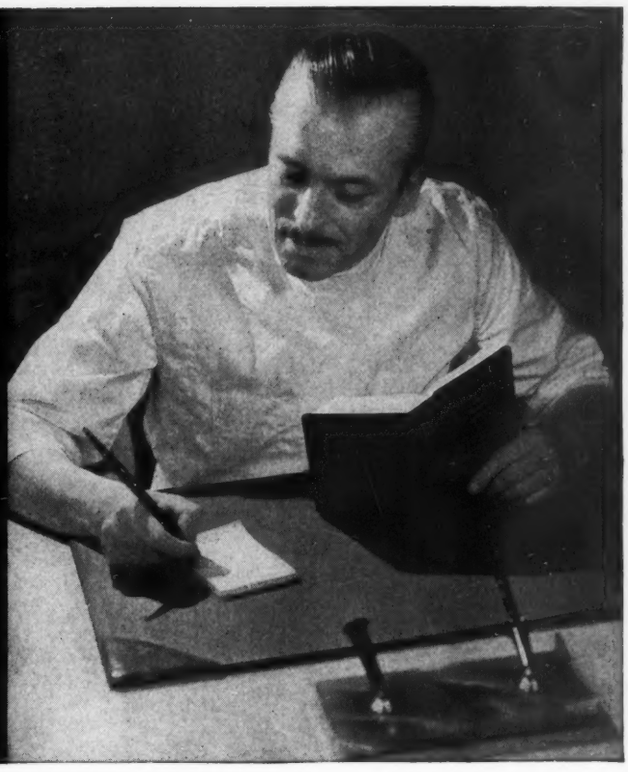

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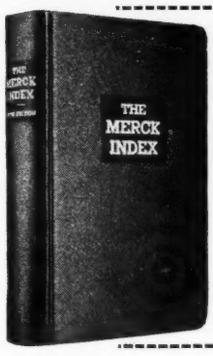

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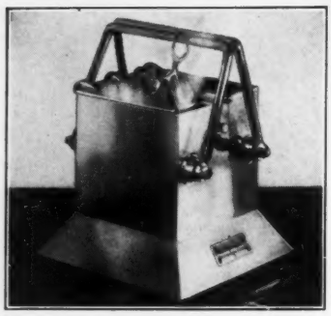

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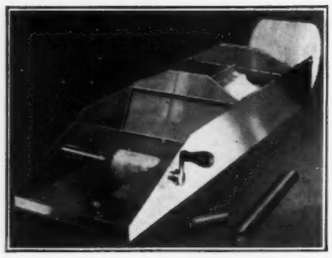

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News in Review

Tri-Staters Hear Defense Story With Estimates on Present Personnel Needs

The hospital's part in the present national defense effort was skillfully outlined to hundreds of hospital people at the main round table session of the Tri-State Hospital Assembly, meeting in Chicago's Hotel Stevens on May 7 to 9. A registration of more than 3500 was recorded for this year's meeting, the largest registration in the assembly's history.

The story on defense was first presented by Dr. Benjamin W. Black, president of the American Hospital Association, and James A. Hamilton, administrator of New Haven Hospital, New Haven, Conn. Dr. Black's paper was reported in the news pages of The Modern Hospital last month and Mr. Hamilton's paper is published on page 43 of this issue. The round table following their presentations carried on the discussion from the point of view of 24 hospital department heads.

It was estimated by Pearl Murray, director of nurses at Deaconess Hospital, Evansville, Ind., that there are 33,000 inactive nurses in the United States who might become eligible for active service through a series of refresher courses offered by hospitals. They could help to make up the deficiency in the supply of trained nurses for civilian care caused by the national defense program.

Refresher courses are being worked out by the national nursing organizations. To be offered by hospital nursing schools, they will consist of from six weeks to three months of hospital training in the fundamentals of general medical, communicable disease, surgical and obstetric nursing, nutrition and materia medica.

It is proposed that supervisors and faculty members of existing nurses' training schools be charged with the responsibility of organizing and teaching the refresher courses. National nursing organizations have expressed the hope that hospitals will be granted some financial assistance from the government in offering such courses.

There is immediate urgent need for more trained physical therapy technicians, Dr. John S. Coulter of Northwestern University Medical School declared before one section of the assembly. The immediate need of government hospitals is for 500 technicians now and about 1200 in the next two years. There is also a shortage of about 250 physicians trained to take charge of physical therapy departments in hospitals, Doctor Coulter stated.

"In the convalescent camps, which are planned as part of Army hospital centers," Doctor Coulter said, "physical therapy should be started in the care of many fractures, dislocations, wounds and amputations. In the World War, physical therapy was most effective in reducing the length of temporary disability and the amount of permanent disability."

There are now approximately 1275 trained physical therapy technicians in the United States. To prevent depletion of this service, Doctor Coulter reported that the 16 approved schools are planning to double the number of classes and to cut the course from twelve months to six months by transferring much of the practical work from the training course to the actual job.

In order to avoid aggravating the shortage of nurses, the approved schools are trying to draw most of their applicants from among the graduates of physical education courses instead of from the nursing field.

The first session of the newly organized purchasing agents' session of the Tri-State Assembly was so well attended that people were standing in the aisles most of the time. An unplanned debate

(Continued on page 110)

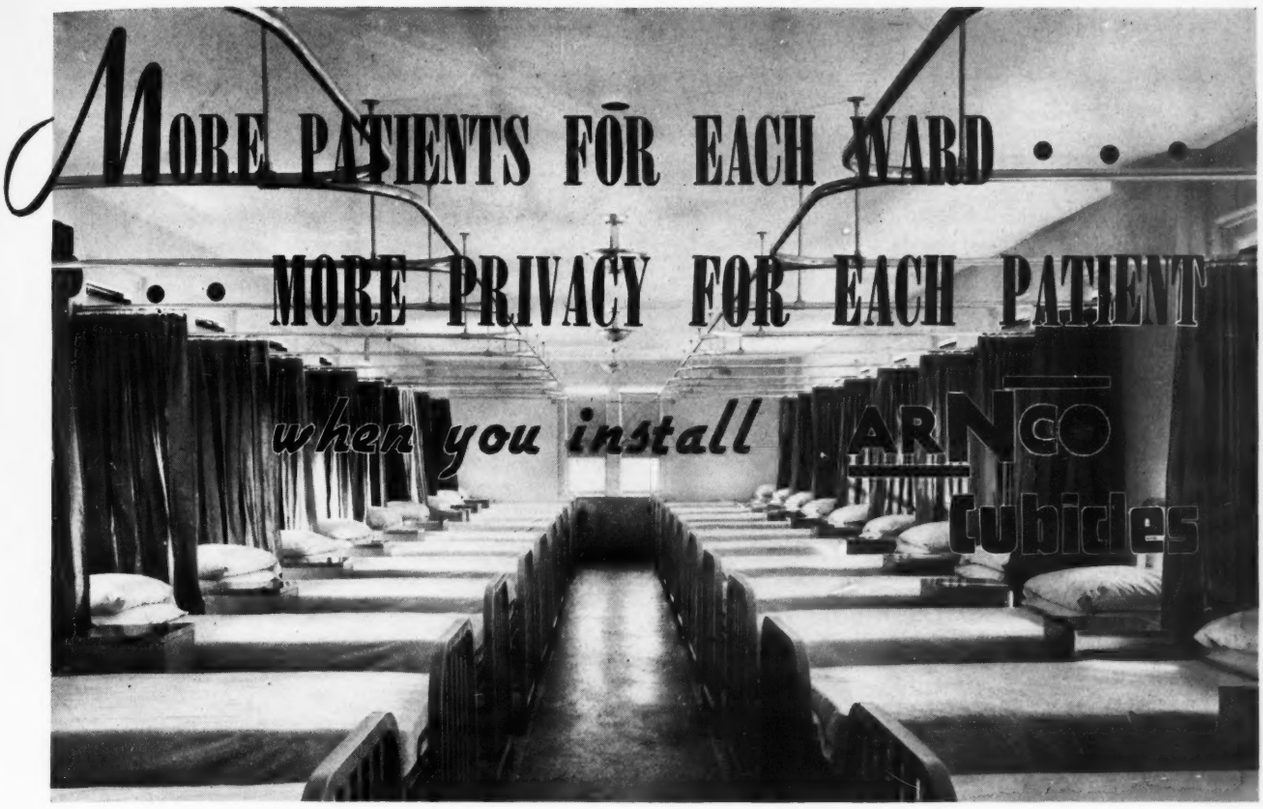
Mediators Preparing Report on West Pennsylvania Strike

Mediators representing the management of the Western Pennsylvania Hospital, Pittsburgh, and the striking employes of the hospital were working on a report to submit to Pittsburgh's Mayor Scully when this issue went to press.

Intimidation of worker by strikers has so frequently resulted in clashes that the hospital returned to an emergency basis. Police and strikers have also clashed.

Published disclosures that John Filer, local head of the C.I.O. state, county and municipal workers union, has a criminal record, as revealed by Representative Hoffman of Michigan, astonished the Pittsburgh public. The Steel City Industrial Union, in response to an appeal by strikers, passed a resolution to support the strike.

As this issue went to press, eight strike leaders faced hearings in the common pleas court on contempt proceedings charging violation of the picketing regulations laid down by the court.



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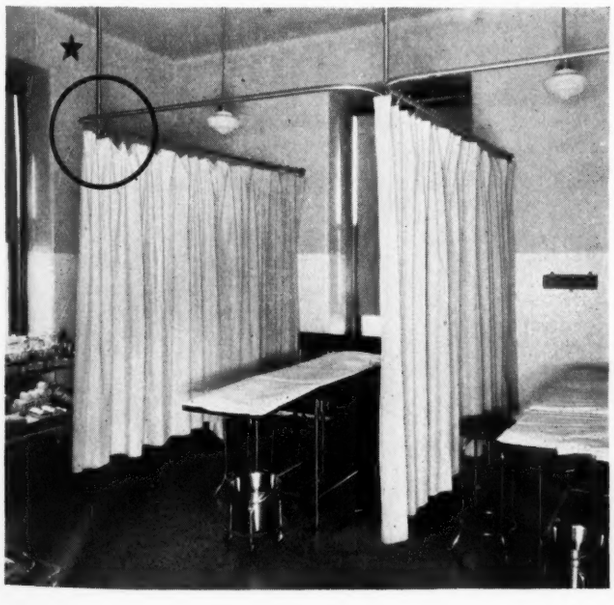

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National Hospital Day Has Military, Defense and Public Health Aspects

Many outstanding programs featured the 1941 observance of National Hospital Day. Some of these are described on page 63.

An unusual feature of the program at New Haven Hospital, New Haven, Conn., was the "quiz corner" where more than 500 of the 2500 visitors determined their own H.Q. (health information quotient). The health tests each contained 25 questions which the person answered by underscoring the answer that seemed to be the best. These were then mechanically graded and the visitor was given his score and a duplicated list of the right answers. A considerable amount of health information was contained in each of the answers.

A total of 19 exhibits was in place, including "How the Blood Bank Works," "Why and How Teeth Decay," "Bones in the Making," "What to Do About Cancer," "How to Become a Nurse" and "A Microbe Hunting Expedition."

Special attention was given to an exhibit by the New Haven defense council and the American Red Cross disaster committee on plans for the care of residents in times of local disaster or national emergency. The local Rotary Club met for luncheon at the hospital and witnessed a demonstration entitled "Action in the Operating Room." This demonstration was repeated four times in the afternoon for the benefit of other guests.

A series of motion pictures on nutrition, cancer, tuberculosis, communicable disease and syphilis was shown all afternoon and evening. The schools of medicine and nursing of Yale University assisted in the tours of the hospital. Two exhibits showed books and other gifts especially suitable for children in hospitals. A puppet show of "Hansel and Gretel" illustrated the work of convalescent children.

A sham battle by the 8th Marine Corps and addresses by Maj. Gen. William P. Upshur of the Marine Corps and Lieut. Comm. W. Perry Wood of the 11th Naval District were highlights of the observance at Paradise Valley Sanitarium and Hospital, National City, Calif. The afternoon attendance was estimated at 3500 with another large group in the evening.

Another large scale demonstration at Paradise Valley showed the effects on the civilian population of bomber attacks on cities and the work of first-aid squads in caring for the civilian injured. Fire precautions necessary during air raids were also shown.

In St. Louis a total of more than three hours of radio time was used from May 5 to 12 for National Hospital Day. One newspaper published an interview with the oldest practicing physician in the city and other papers published many rotogravure pictures. The street cars issued special Sunday passes and car cards advertising the day. More than 400,000 milk bottle collars were used. Seven schools of nursing in the city held simultaneous teas on Monday afternoon and demonstrated steps in the training of a student nurse and advice on home nursing.

The mayor of St. Louis and the mayors of all municipalities in the county were present at a flag dedication on the grounds of St. Louis County Hospital on Sunday. American Legion and British Canadian War Veterans' Association members participated.

A distinctly constructive note was sounded by the social planning council of St. Louis, which invited 1500 hospital trustees, administrators, members of women's auxiliaries and leaders in the health field to a tea for a discussion by the deans of the two local medical schools on the need for planning future hospital facilities.

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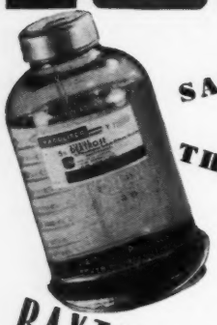

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Carolinas-Virginias Workers Trade Ideas on National Defense and Administration

After three days spent in listening to and participating in discussions of pertinent topics, inspecting exhibits and exchanging ideas, hospital executives attending the Carolinas-Virginias Hospital Conference in Greenville, S. C., returned to their posts with renewed confidence to meet the many problems facing them.

The eleventh annual meeting was in many respects one of the conference's most successful, its show numbering more than 60 exhibits and assuming almost the importance of a national display. The social program was carefully planned and efficiently carried out by Mrs. Byrd B. Holmes, president of the conference, and her associates.

The place of the nurse in national defense was emphasized by Alice Dugger, nursing consultant, American Red Cross, who made the statement that 4019 graduate nurses will be needed by June 1 above the regular Army nurses. Furthermore, she estimates that 5000 nurses will be needed in the national defense program every year for the next five years in addition to the Army nurses.

According to the experience of Dr. John Elliot, Rowan Memorial Hospital, Salisbury, N. C., blood plasma is a life-saver. The cost of preparing plasma is not great, Doctor Elliot says, and he has found also that using plasma immediately after its removal from a refrigerator is a safe procedure.

In speaking on the importance of association work, Dr. Arnold F. Emch, assistant secretary, American Hospital Association, made the statement that those who disparage the value of hospital meetings disparage the value of their own work. "There is no such thing as a Robinson Crusoe hospital today," he declared. "No one hospital can fight all its present problems alone; organized effort is required."

Auxiliaries came in for their share of attention, particularly the small hospital auxiliary. Mrs. Paul Dana, past president of Moore County Hospital auxiliary, Pinehurst, N. C., described the activities of her auxiliary. The importance of the motor corps as an aid to the social service work in taking indigent patients to the hospital for checkup was one of the services mentioned.

In discussing good hospital publicity, Raymond P. Sloan, editor of The Modern Hospital, made the statement that greater than any story that may be written about a hospital is the voice of the worker raised in its behalf. That constitutes hospital spirit without which no institution can be considered completely successful.

The hospital worker, in fact, should be made to feel that he and his job are important, W. N. Walters, Lewis-Gale Hospital, Roanoke, Va., contended. A definite program of personnel training is essential, he believes. It encourages the employe to speak in terms of "our" hospital, "our" department, "our" patients. The training program should center around regular monthly meetings at which the administrator does as little talking as possible, letting others express themselves.

As might be expected, problems attendant upon the national defense program were not overlooked. Among the points stressed by Charles H. Dabbs, administrator, Tuomey Hospital, Sumter, S. C., was the importance of obtaining adequate personnel, canvassing the community if necessary for available workers. He urged refresher courses for those who have been inactive and also a study of available beds, evacuating patients not

(Continued on page 120)

Mount Sinai Enlarges Facilities With $300,000 Building Project

Addition to and expansion or refinement of facilities in practically every department of Mount Sinai Hospital, Chicago, are included in the $300,000 construction project recently announced by Morris Kurtzon, president of the board of directors.

Clinic facilities and wards are being remodeled and three floors will be added to the present main building, making the hospital a nine story structure. A two story and basement building will be built directly adjoining the east end of the present building in which surgery facilities, laboratory workrooms and increased dining room space for hospital personnel will be located.

At the north end of the present building, a one story and basement building will be constructed to be used as a lobby and waiting room for clinic patients and visitors. The basement will be used as a rest room for graduate nurses and as a drug preparation room. The present emergency room will be remodeled and a new ambulance entrance will be built.

Medical Society Approves Plan

The Chicago Plan for Hospital Care was recently approved by the council of the Chicago Medical Society. Although the medical society is represented on the board by several members, the society originally did not display a friendly attitude toward the plan and even arranged to have members take out policies in a commercial plan.

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Perhaps as you have accepted resignation upon resignation—as you have seen department after department relinquish trained personnel to the Defense Program—you have wondered about replacements. In common with most executives you have probably discovered that few people experienced in the professions which contribute to hospital efficiency are actively seeking appointments at this time.

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PALMOLIVE BUILDING CHICAGO

Cancer Clinics, Plasma Banks, Buying and Defense Concern Midwesterners

If war comes, it will then be too late to prepare for it. This was the warning sounded by Dr. Benjamin W. Black to the Midwest Hospital Association at its meeting in Kansas City, Mo., April 24 and 25.

"If mobilization reaches 4,000,000 men, nearly 30,000 doctors will be needed," Doctor Black declared, pointing out that this would seriously dislocate present methods of caring for the civilian sick.

He stated that Army plans would seem to require somewhere between 160,000 and 240,000 hospital beds, which, in turn, will call for from 19,200 to 28,800 nurses, since the Army ratio is 12 nurses for each 100 beds.

A full-blown cancer clinic that will meet the approval of the American College of Surgeons is quite expensive and is not likely to be economically self-supporting, according to Dr. E. Kip Robinson, executive officer of the cancer clinic at Kansas City General Hospital No. 1, Kansas City, Mo. This is true because, as a rule, patients with cancer have nearly exhausted their funds before they get to the clinic.

The treatment of cancer, Doctor Robinson declared, is a cooperative venture involving surgery, radiology, pathology and, if possible, genito-urology, dermatology, proctology, neurology, dentistry, orthopedics and ophthalmology.

About one third of the patients in a cancer clinic are treated by radium, another third, by x-ray and a third, by surgery. In a small hospital, Doctor Robinson suggests that a cancer clinic can function with considerable success if it has only a surgeon, a radiologist and a pathologist and if all radium is rented.

Many advantages of blood plasma banks over blood banks were cited by Dr. Ferdinand C. Helwig, pathologist of St. Luke's Hospital, Kansas City. He stated that plasma is more stable, has better buffer capacity, has greater ability to restore the irritability of protoplasm and, in general, is safer and more convenient to use. A nurse can be taught to do everything necessary to harvest plasma, Doctor Helwig declared.

Some of the vagaries in the price movements of hospital commodities were outlined by Will Ross, chairman of the public relations committee, Hospital Industries Association. He pointed out that the price rises heretofore witnessed are probably small compared to those that may come and yet that, while some prices have gone up, other prices on closely related products have remained stationary or have gone down.

Mr. Ross warned hospitals of the dangers of putting in very large inventories on the assumption that prices

(Continued on page 112)

Single Group Enrollment Makes Michigan Hospital Care Plan Second Largest

A 300,000 enrollment of Chrysler Corporation and Briggs Mfg. Co. employes and their families in the Detroit hospital and medical prepayment care plans is swelling the ranks of registrants in Michigan Hospital Service.

When enrollment is completed this will be the second largest plan of its kind in the country and Michigan Medical Service will become the largest medical care plan in existence today.

"The fact that such a large group of people is prepared to budget for health in this way is a spectacular demonstration that the American people are willing and able to provide for hospital and medical care costs on a prepayment basis," John R. Mannix, director of Michigan Hospital Service, stated.

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375 Iowans Assemble for Most Successful Meeting; Seek Help on Indigents

Definite steps were taken to increase the rates being paid by counties and townships in Iowa for the care of indigent patients in voluntary hospitals when the Iowa Hospital Association met in Des Moines, April 21 to 23.

A comprehensive report on county rates to hospitals was made by Lillian Zindell, administrator of Atlantic Hospital, Atlantic, Iowa. She found tremendous variation with most of the counties in the state paying rates that are far below reasonable cost. A committee has been directed to work on this subject during the coming year.

With a registration of 375, this was the most successful meeting in the history of the Iowa Hospital Association. The dietitians, record librarians, x-ray technicians, nursing educators, occupational therapists, nurse anesthetists and hospital pharmacists met with the administrators. All future meetings will be held in Des Moines because of its central location and adequate hotel facilities.

A refresher course offered to the older graduates of the Iowa Methodist Hospital, Des Moines, was described by Florence Wesslund, superintendent of nurses. Among the subjects presented were the following: charting, Wangensteen suction, intravenous solutions, oxygen therapy, pneumonia, diabetes, pediatrics (especially the feeding of children), nasal lavage, tracheotomy, blood pressure, asepsis and antisepsis, obstetrics and care of the new-born, and new medications (especially sulfanilamide and its derivatives).

The course had excellent attendance and a high degree of interest, Miss Wesslund reported. It is planned to repeat the course next year and to give additional subjects.

A sound credit and collection policy is based on a sound policy for financing the hospital, according to Albert H. Scheidt, administrator, Miami Valley Hospital, Dayton, Ohio, one of the guest speakers. Mr. Scheidt urged all hospitals to make a specific financial plan for caring for four classes of patients: (1) the indigent, (2) the part-pay, (3) those who can pay full cost but no more and (4) those who can pay more than cost without real hardship.

Mary Elder, Burlington Protestant Hospital, Burlington, was chosen president to succeed R. J. Connor of the University of Iowa Hospitals. Other officers are: first vice president, Paul Hanson, Iowa Lutheran Hospital, Des Moines; second vice president, Sr. Mary Ursula, Mercy Hospital, Dubuque; secretary, Orville Peterson, Memorial Hospital, Eldora; treasurer, A. L. Langehaug, Lutheran Hospital, Fort Dodge. A.H.A. delegates are Dr. John Peck, State Sanatorium, Oakdale; Mrs. Grace Heller, Sioux Valley Hospital, Cherokee. A.H.A. alternates are T. P. Sharpnack, Broadlawns Hospital, Des Moines; Rev. F. Kaufman, diocesan director of Catholic hospitals of Iowa, Dubuque.

East Bay Hospitals Plan Refreshers

A committee, under the chairmanship of Marian Alford, director of nursing, Peralta Hospital, Oakland, Calif., has been appointed by the nursing directors of East Bay hospitals to organize refresher courses for retired nurses who might be encouraged to reenter the field. The curriculum will review medical, surgical and obstetrical nursing, with particular stress on the newer developments in nursing procedures and in medicolegal aspects of the work.

Canton Improves Nurse Housing

The new nurses' homes in Canton, Ohio, have been approved by their respective boards. At Mercy Hospital, work has begun on a $375,000 nurses' home and training school, and Aultman Hospital has purchased an old home and remodeled it to house 25 students. When completed, the new Mercy Hospital structure will accommodate 130 nurses.

ON THE RECEIVING LINE AGAIN

FLOORS OF *Terrazzo* *

FROM the number of reception rooms with TERRAZZO floors you would say that hospitals have found a mighty good "greeter." In the De Paul Sanitarium in New Orleans, there are three more rooms like the one illustrated. And TERRAZZO is in the corridors, too.

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4. COLOR AND DESIGN. Terrazzo has warmth and beauty. You may specify *any design* you wish—pictorial or geometric—in virtually *any combination of colors.*

5. DEPENDABLE INSTALLATION. This Association's objective is to see that your Terrazzo installations *turn out exactly as you want them.* Write us today for complete information on the above points or see our advertisement in Sweet's Catalog for basic technical data.

De Paul Sanitarium, New Orleans, La. Architects: Andry & Feitel of New Orleans.

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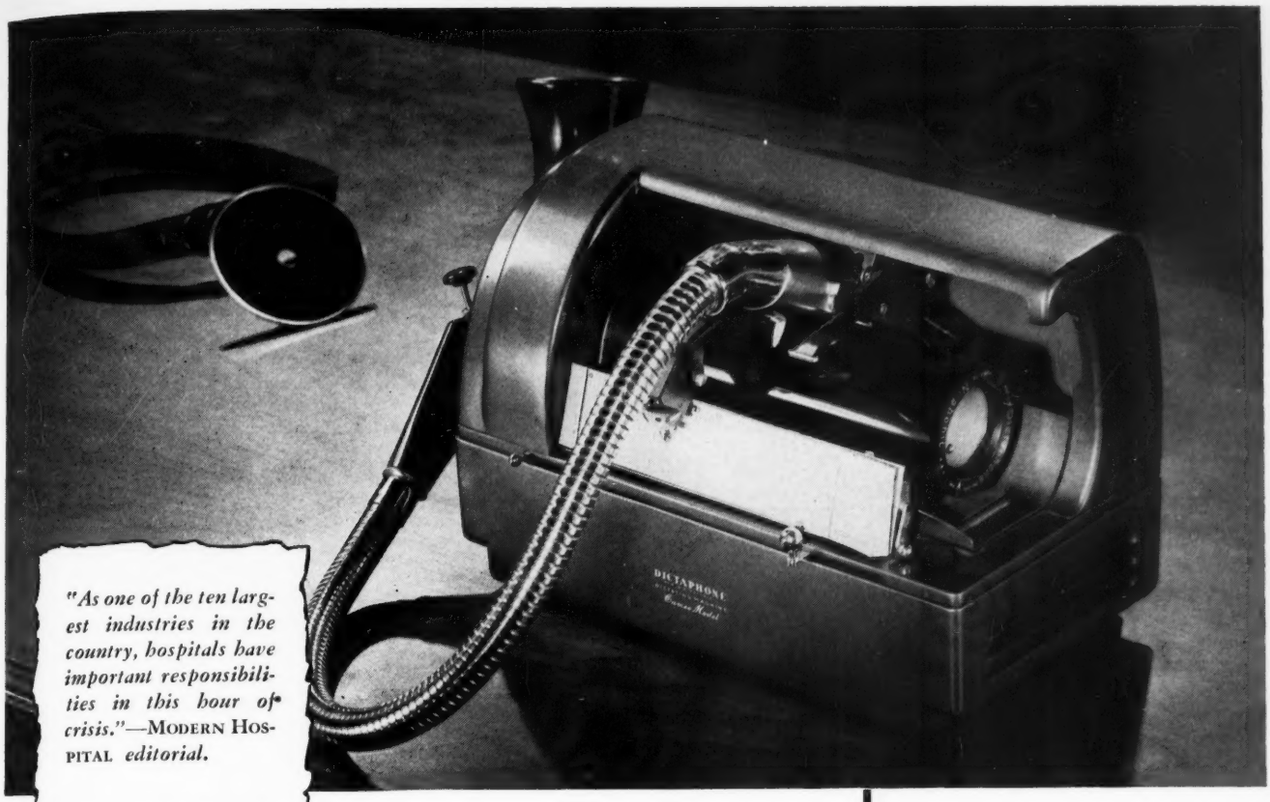

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Tri-Staters Hear Defense Story and Personnel Needs

(Continued from page 100)

on the merits of group purchasing was staged between Albert H. Scheidt, administrator of Miami Valley Hospital, Dayton, Ohio, and former executive secretary of the Chicago Hospital Council, and Eugene E. Salisbury, present executive secretary of the council. Their discussion is to be published shortly in The MODERN HOSPITAL.

Because the members of the section are located in the four states that constitute the assembly, it was decided to publish a monthly bulletin to exchange information and market trends. C. O. Auslander, purchasing agent, Michael Reese Hospital, Chicago, was designated editor of the bulletin as well as chairman of the section for next year.

Officers elected by state hospital associations are as follows:

Illinois Hospital Association: president, Charles A. Lindquist, Sherman Hospital, Elgin; first vice president, Sr. M. Cecelia, St. Joseph's Hospital, Bloomington; second vice president, William H. Tenney, Illinois Masonic Hospital, Chicago; secretary-treasurer, Victor S. Lindberg, Victory Memorial Hospital, Waukegan; trustees, Myrtle McAhern, Blessing Hospital, Quincy; Stuart K. Hummel, Silver Cross Hospital, Joliet; Rev. Joseph A. George, Evangelical Hospital, Chicago; Frank W. Hoover, Decatur-Macon County Hospital, Decatur.

Michigan Hospital Association: president, Graham L. Davis, Kellogg Foundation, Battle Creek; first vice president, Rev. J. L. Ernst, Evangelical Deaconess Hospital, Detroit; second vice president, J. A. Blaha, Grand View Hospital, Ironwood; secretary, Robert Greve, University of Michigan Hospitals, Ann Arbor; trustees, Ralph M. Hueston, Hurley Hospital, Flint; Mrs. Kate J. Hard, Saginaw General Hospital, Saginaw; Mrs. Jessie F. Bernard, Cottage Hospital, Grosse Pointe; Sr. Assissium Hynes, Mercy Hospital, Jackson.

Indiana Hospital Association: president, Hannah Rosser, Vermillion County Hospital, Clinton; vice president, Maude Woodward, Putnam County Hospital, Greencastle; treasurer, Frank G. Sheffler, Union Hospital, Terre Haute; executive secretary, Albert G. Hahn, Deaconess Hospital, Evansville; trustees, Nellie G. Brown, Ball Memorial Hospital, Muncie; Sr. M. Theotima, St. Anthony's Hospital, Terre Haute.

Coming Meetings

June 1-7—American Association of Medical Social Workers, Atlantic City, N. J.
June 16-20—Catholic Hospital Association, Convention Hall, Philadelphia.
June 19-21—Group Health Federation of America, Inc., Milwaukee.
June 23-27—Canadian Medical Association, Royal Alexandra, Winnipeg, Man.
July 2-3—Hospital Association of Nova Scotia and Prince Edward Island, Hotel Nova Scotian.
July 2-3—Hospital Association of New Brunswick, Hotel Nova Scotian.
July 17-18—Mid-West Institute for Hospital Administrators, University of Colorado School of Medicine and Hospitals, Denver.
Aug. 17-19—National Hospital Assn., Chicago.
Aug. 20—Maine Hospital Association, Lakewood Inn, Lakewood, Maine.
Sept. 12-14—American Protestant Hospital Association, Atlantic City, N. J.
Sept. 13-15—American College of Hospital Administrators, Atlantic City, N. J.
Sept. 15-19—American Hospital Association, Atlantic City, N. J.
Oct. 8-10—Ontario Hospital Association, Royal York, Toronto.
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.
Oct. 20-23—American Dietetic Association, Hotel Jefferson, St. Louis.
Oct. 23-24—Missouri Hospital Association, St. Louis.
Oct. 24—Idaho Hospital Association, St. Joseph's Hospital, Lewiston.
Oct.—Saskatchewan Hospital Association, Moose Jaw, Sask.
Oct.—British Columbia Hospital Association, Empress Hotel, Victoria.
Nov. 13-14—Kansas Hospital Association, Topeka.
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.
Nov. 17-28—Southwestern Institute for Hospital Administrators, Southern Methodist University, Dallas, Tex.
Dec. 4—Utah Hospital Association, Salt Lake City.
Jan. 1942—Wisconsin Hospital Association, Hotel Schroeder, Milwaukee.
Feb. 26-28, 1942—Texas Hospital Association, Houston.
April 27-29, 1942—Iowa Hospital Association, Fort Des Moines Hotel, Des Moines, Iowa.

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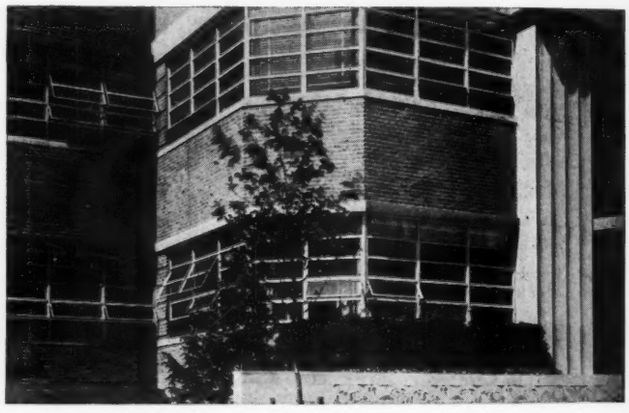

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AN AMAZING *New Safety Pin* PREVENTS THESE DANGERS

TINY PIN SCRATCH SERIOUS TO NURSE
An innocent pin prick may become a serious infection. A Safe Safety Pin lessens this hazard.

BABY SWALLOWS *OPEN* SAFETY PIN
The Safe Safety Pin eliminates the ever present danger of an old fashion safety pin for *open* or *closed* the point is *always* securely protected.

PATIENT INFECTED BY UNFASTENED PIN
A safety pin becomes unfastened—a patient is scratched, infection can be the result. A Safe Safety Pin lessens this danger.

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IT'S CLOSED WHEN OPEN

It's amazingly simple. So obvious you'll wonder why someone hasn't thought of it before! *Closed,* it looks like an ordinary safety pin. *Opened,* its protected point rests securely in a guarded groove, no dangerous point protrudes to prick or scratch.

But safety is only one of the reasons why you'll want them for your hospital. They save time (and often seconds are precious), for *open* they are as safe to handle as any ordinary safety pin when *closed.* They hold more securely, greatly eliminate the danger of snapping open in use. Their ease of operation, their security, plus the utter safety of the SAFE SAFETY PIN will give your nurses and doctors greater peace of mind. As a result their work will be swifter and more efficient.

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This new safety pin *was designed especially for hospitals* upon the suggestions and recommendations of doctors and nurses. You will want to follow the lead of progressive hospitals everywhere that are welcoming this new innovation.

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Interns and Medical Students Are to Be Deferred in Draft

Both interns and medical students are to be kept at their studies until completion rather than being called immediately for military service under the terms of a memorandum (I-91) sent out on May 2 by national headquarters of the Selective Service System.

Studies by the Office of Production Management "conclusively demonstrated that the medical profession constitutes an activity essential to the national health, safety and interest and that a serious interruption or delay therein is likely to impede the national defense program," according to the memorandum.

The national defense program as now outlined will require a total of 9000 doctors for the Army, Navy, Public Health Service and Veterans' Administration, according to the report, which goes on to point out that the expanding defense program greatly increases industrial hazards to workers and that the rapid growth of communities throughout the country through the establishment of new defense industries presents serious health problems. All this indicates an increased demand for physicians of about 10 per cent.

Local draft boards still have the responsibility of deciding whether practicing physicians are so necessary to their communities that they should be deferred from Army duty. In reaching this decision, the boards are directed to appreciate clearly the overall national shortage.

Specific attention is called to the fact that a deferment is not an exemption and that the obligation for military service remains upon its expiration.

The same rules apply to interns, except that they can be commissioned in the Medical Reserve Corps and, if so commissioned, will not be called to active duty during their first year.

Midwesterners Discuss Clinics, Blood Banks, Buying, Defense

(Continued from page 106)

would rise sharply. "Future price changes are not known and administrators who use the hospitals' funds to make huge purchases are gambling with other people's money," he asserted.

Deliveries are the principal concern today and administrators should anticipate their needs further in advance, according to Mr. Ross. He urges that hospitals standardize on standard merchandise since it takes far more time and trouble to run a special order through the mill. High stock inventories mean that more fire insurance is needed, depreciation is greater and hospital personnel is more likely to be careless in its use of supplies, he concluded.

With a registration of 601, the Midwest Hospital Association and its eight affiliated sections, showed a gratifying growth from the meeting in Hot Springs, Ark., in 1939 where the total registration was 208.

New officers of the Midwest Hospital Association are: president, E. E. King, Missouri Baptist Hospital, St. Louis; president-elect, Florence King, Jewish Hospital, St. Louis; first vice president, L. C. Austin, Menorah Hospital, Kansas City; second vice president, Rev. William Schaefers, St. Francis Hospital, Wichita, Kan., and secretary-treasurer, Jack Latcham, Colorado General Hospital, Denver.

The new trustees are: Dr. Charles Holt, Sparks Memorial Hospital, Fort Smith, Ark.; Grange Sherwin, St. Luke's Hospital, Denver; Elizabeth Woolsen, Axtell Christian Hospital, Newton, Kan.; Ray F. McCarthy, Group Hospital Service, St. Louis; Bryce L. Twitty, Hillcrest Memorial Hospital, Tulsa, Okla.; R. L. Loy, Oklahoma City Hospital, Oklahoma City; J. O. Bush, Bone and Joint Hospital, Oklahoma City; Mrs. Ursula Frantz, Mennonite Deaconess Hospital, Beatrice, Neb.; Francis Bath, St. Joseph's Hospital, Omaha, and Dr. Francis Bean, University Hospitals, Omaha.

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Hemorrhage, shock, asthmatic spasm, asphyxia, nitritoid reaction are other critical conditions which may call for the prompt use of suprarenalin. But it is important to make certain that the preparation upon which you depend in these emergencies is potent, efficient, standardized and pure. Behind Suprarenalin (Epinephrin) ARMOUR are forty-five years of painstaking research in the manufacture of endocrine preparations. Only the most select of our tremendous supply of fresh animal glands are employed and every step in the processing is carefully supervised and checked to insure a product that meets the high and unvarying ARMOUR LABORATORIES standard.

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available in these forms:

SUPRARENALIN SOLUTION 1:1000
Supplied in 1 cc. ampoules and 1 oz. rubber-capped vials.

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Supplied in 1 grain vials.

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Supplied in ¼ oz. and 1 oz. bottles for oral inhalation.

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Supplied in collapsible tubes with applicators.

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1 cc. ampoules for hypodermic or intravenous use.

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CHICAGO, ILLINOIS

Defense Program, Care of Indigent Are Concern of New Jersey Delegates

The program of the local community defense council working with existing community organizations is threefold, according to Hon. William J. Ellis, commissioner of the department of institutions and agencies, Trenton, speaking before the seventeenth annual convention of the New Jersey Hospital Association. It consists of service to enlisted men, industrial workers and the civilian population.

Close attention was directed by the representative group of New Jersey hospital people who met, as usual, in Atlantic City upon this and other phases of the defense program. It was the first problem listed on the program and hardly a speaker failed to touch upon it.

In the well-formulated program on defense, which got the three day conference off to a good start, I. E. Behrman, director, Beth Israel Hospital, Newark, stressed the importance of coordination. The individual hospital should be one part of a single, efficient organization consisting of a great number of service agencies. The responsibility for that coordination must be vested in a special body of authority which is created for that purpose.

Marie Wooders of Hackensack Hospital, president of the New Jersey State League of Nursing Education, urged all nurses to take additional courses in emergency and first-aid work. "Courses in first aid given in our schools of nursing have been inadequate," she said. "Many lay groups in the East are better prepared than most of our nurses."

"During peace years there are approximately 1200 physicians in the Army; this must be expanded," said Dr. D. W. Scanlan of Atlantic City, "by the first part of July at the rate of 7½ physicians per thousand of Army personnel, or approximately 9000 physicians." In the ensuing discussion the need for as many as 7½ physicians per thousand of Army personnel was challenged, the feeling being that this was unnecessarily high.

F. Stanley Howe, president of the association and administrator, Orange Memorial Hospital, said in his report: "Viewing the situation today, it would seem as though our greatest problem was financing care for the indigent sick.

"In the lush days of the E.R.A. it may have seemed that the generous hand of a paternalistic government would continue to reimburse us for the care we were giving to the unemployed and underprivileged. This mirage has gradually faded, leaving us confronted with a new set of technicalities which municipal governments have adopted as their own, following the pattern of the state distributing authorities.

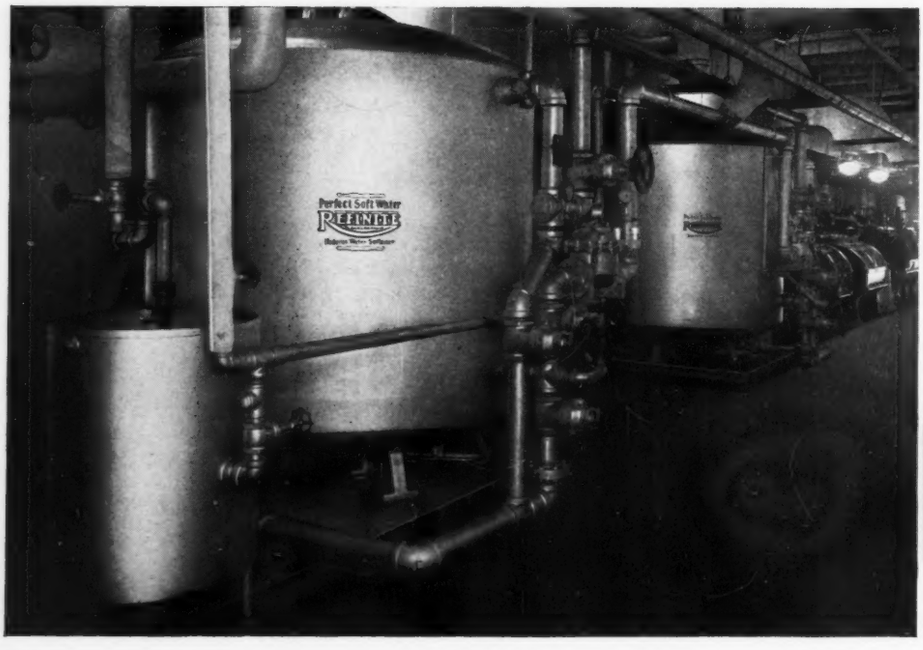
"Beneath all this the clear legal responsibility of the community to pay the hospital for the care of its indigent sick has been lost sight of and most of us are feeling the lack of adequate municipal payments for which we stand in increasing need."

Otis N. Auer, director, Monmouth Memorial Hospital, Long Branch, was elected president of the association and Florence Burns, superintendent, Somerset Hospital, Somerville, was chosen president-elect. Dr. J. Berkeley Gordon, medical director, New Jersey State Hospital, Marlboro, will serve as vice president. Thomas J. Golden, Medical Center, Jersey City, was reelected treasurer.

Denver Adopts Standard Discounts

Discounts adopted by the Denver Hospital Council are listed as follows, according to word received recently from Frank J. Walter, secretary: attending doctors, 100 per cent; associate doctors, from 50 to 100 per cent; all other doctors, 25 per cent; interns, 100 per cent; medical students, 25 per cent; dentists, 10 per cent; clergy, 25 per cent; doctors' secretaries, 10 per cent; other hospital employes, 25 per cent; nurses, alumnae members, 33 1/3 per cent; nurses, non-alumnae members, 15 per cent.

REFINITE WATER SOFTENER IN STEVENS HOTEL *Pays for Itself!*



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Today, the modern hospital is a business institution as well as a haven for the sick . . . where every scientific facility is provided to relieve human suffering and make sick people well. As a business institution, the hospital must buy its equipment and supplies wisely. It takes money to run a hospital. "Dead roosters" don't count.

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Ohio Reports Successful Legislative Achievements to Association Meeting

An outstanding year for the Ohio Hospital Association from the legislative standpoint was reported at the convention of the association on April 29 to May 1, by Dr. M. F. Steele, Christ Hospital, Cincinnati, who is chairman of the state relations committee.

Since the Ohio law for compensation of hospitals for care rendered to indigent victims of auto accidents went into effect, the hospitals have received a total of $1,688,000. Payments have been made to 98 Ohio hospitals for approximately 12,000 claims. During 1940 the payments totaled $290,595.

Considerable discussion has been carried on between the Ohio Hospital Association and the bureau of motor vehicles over the rate of payment. While the law states that payment shall be on the basis of per capita per diem cost, the state officials do not like to pay this amount when it exceeds the present actual charges made by the hospitals to other patients. The association has strongly urged all Ohio hospitals to revise their rate schedules so as not to offer service at less than cost.

In connection with the work of the state industrial commission, the association has agreed to a long list of findings by the auditor who was appointed to verify the hospitals' statement of costs. The auditor recommended that, in computing cost per patient day, the following items, among others, should not be included in expenses: free and courtesy service, discounts granted or losses on patients' accounts, bad debts charged off, interest or principal payments on capital debts, operation of out-patient departments, value of volunteer services unless these are continuous, expenses of property not occupied by the hospital, real estate and property taxes when the hospital is tax free and cash refunds to patients.

Instead of a hospital lien law the Ohio Hospital Association has worked out a gentleman's agreement with the representatives of the casualty insurance companies.

An amendment has been passed to the dental code of the state which authorizes the dental board to issue a special certificate to dental interns in accredited hospitals.

Stamford Superintendent Dies

George Frank Sauer, superintendent, Stamford Hospital, Stamford, Conn., died following an operation. Mr. Sauer had occupied the Stamford position for nine years.

Service Plans Institute Draws Attendance From Eight States

Sixty-one members attended an institute for enrollment representatives of approved hospital service plans serving the Midwestern States, which was held in Chicago on May 5 and 6.

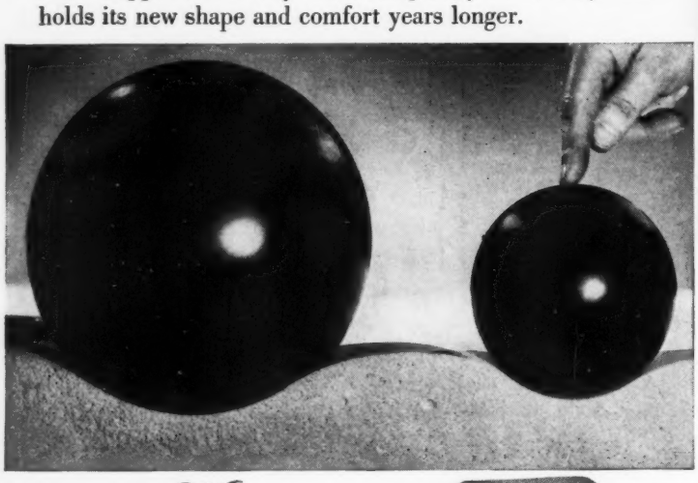
Fourteen approved plans with headquarters in Alton, Danville, Chicago, Peoria and Rockford, Ill., Des Moines, Iowa; Louisville, Ky., Detroit, Mich., St. Paul, Minn., St. Louis, Mo., Cincinnati, Columbus and Newark, Ohio, and Milwaukee, Wis., were represented.

The purpose of the institute was to give those individuals engaged in field work the advantage of methods and ideas in successful use in other communities and to report the most recent developments in hospital service plan programs. Special emphasis was placed upon the objectives of plans and technics of presentation.

It was the consensus of the group that commercial insurance competition was not acute and that the service benefits of plans might be supplemented but could not be supplanted by indemnity contracts. Reciprocity of enrollment among approved plans and service benefits for nonmember hospital care were discussed in relation to enrollment of large and small, local and national accounts.

A MORE RESTFUL MATTRESS FOR YOUR PATIENTS (and you, too!)

Koyalon combines both softness and springiness in a single material. It replaces old-fashioned mechanical parts and padding with one sag-proof, molded unit—supports the body more completely and evenly—and holds its new shape and comfort years longer.



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ESPECIALLY HELPFUL TO ALLERGICS—hairless, lintless, dustless!

HERE'S HOW *Koyalon* WORKS FOR BETTER REST—These bowling balls show how perfectly Koyalon adjusts itself to different weights. Weights that could be head, shoulders, hips. Correct support for each part of the body makes Koyalon more restful. Koyalon supports more *completely*, too. Because it shapes itself exactly to every body contour.

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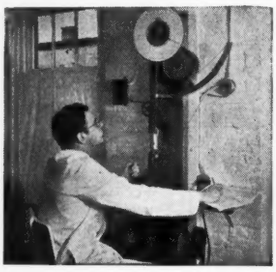

Testing laboratory strength of fabric used in Marvin-Neitzel garments.

Mrs. Rich Noticed It Too

Mrs. T. Rich: I have never seen a better looking group of student nurses.

Superintendent of Nurses: I am glad you like them. We have been careful to select uniforms that are smart.

Mrs. T. Rich: They are not only smart, they fit so well. Who makes them?

Superintendent of Nurses: Marvin-Neitzel Corporation. They have a reputation for style, fit and quality. And their uniforms are made of *Sanforized Shrunk materials.

Mrs. T. Rich: Well, that's the answer. I remember another hospital I was in that also used Marvin-Neitzel uniforms. They too were good looking. It seems so good to have attractive looking nurses care for you. You know they really help one.

* * * *

The above conversation is not unusual where Marvin-Neitzel uniforms are used. Hospital superintendents have been complimented a great many times because of the excellent appearance of their Marvin-Neitzel uniformed nurses. These uniforms are not only good looking but they wear longer; consequently, they cost less.

*Sanforized Shrunk Fabrics will not shrink more than 1% by standard test—CCC-T-191a.

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Eight Catastrophe Units Added to New York City's Disaster Control System

Mayor La Guardia's disaster control board for New York City was further implemented last month by the Department of Hospital's completion of eight additional catastrophe units, bringing the total in the five boroughs to 12, capable of transporting to the scene of any major disaster a corps of especially trained physicians and nurses supplied with medical and surgical equipment comparable to that of a first-aid station.

Dr. Willard C. Rappleye, commissioner of hospitals, declares that the efficacy of these units has already been demonstrated by the four catastrophe units that were organized with the disaster control board last year at Bellevue Hospital for Manhattan; Kings County Hospital for Brooklyn; Queens General Hospitals for Queens, and the Morrisania Hospital for The Bronx.

The additional units completed are at Presbyterian, New York and Roosevelt hospitals for Manhattan; Fordham Hospital for The Bronx; Cumberland, Greenpoint and Coney Island hospitals for Brooklyn, and Sea View Hospital for Staten Island.

As a sample of unit organization, the Bellevue catastrophe unit is composed of two squads of doctors, each made up of a captain and 12 men, each squad subject to call at definite hours. As the nurses are on eight hour periods of duty, it is necessary to provide three nursing squads of the same size as the medical squads, similarly assigned and especially trained in handling emergencies.

Orderlies also accompany the squads for help in loading and unloading equipment and rendering such other assistance as is required. All ambulance drivers assigned to the hospital are also subject to call in an emergency.

Kansas Passes Insurance Bill

A bill to provide for state-wide hospital care insurance has been passed by the Kansas state legislature. This crowns with success the long effort of the Kansas Hospital Association in behalf of the bill. It specifies that the trustees of a hospital service plan must represent in equal proportions hospital superintendents or trustees, licensed physicians exclusive of the foregoing and members of the general public exclusive of both of the two preceding groups. Municipal, county, proprietary and voluntary hospitals may participate in the plan but at least 20 participating hospitals are required to begin operations. Strict limitations are placed on expenditures.

Middlewestern Trustee Conference to Be Held at University of Chicago

A second hospital trustees' conference sponsored by the University of Chicago and the Kellogg Foundation will be held at the university on June 12 to 14, according to an announcement last month from the university offices.

Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics and president of the American College of Hospital Administrators, will be director of the institute with Graham L. Davis of the Kellogg Foundation and Gerhard Hartman of the A.C.H.A. as associate directors.

The faculty of the institute probably will include James A. Hamilton, New Haven Hospital, New Haven, Conn.; Dr. W. S. Rankin, Duke Endowment, Charlotte, N. C.; Ada Belle McCleery, trustee, Delnor Hospital, St. Charles, Ill.; Dr. Claude W. Munger, St. Luke's Hospital, New York City; Dean W. H. Spencer, school of business, University of Chicago; C. Rufus Rorem, commission on hospital service, Chicago; Dr. Malcolm T. MacEachern, American College of Surgeons, Chicago, and the director.

The conference is open to trustees of hospitals in the Middle West.

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(1) "There is no known substitute for a steady, well balanced diet carrying liberal quantities of the protective foods. Such diets will provide all the known essential food nutrients in adequate amounts and in addition furnish some measure of safety against inadequacies of essentials about which there is at present no knowledge." J. Am. Med. Assn. 114, 548 (1940). American Can Company, 230 Park Avenue, New York, N. Y.

The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

Carolinas-Virginias Workers Trade Ideas at Conference

(Continued from page 104)

critically ill if necessary. Mr. Dabbs spoke, too, of the necessity for studying the possibilities of expansion to take advantage of our present facilities and to see what emergency arrangement might be effected within the community.

Meetings held simultaneously with that of the hospital group were the South Carolina Dietetic Association and the North Carolina Association of Medical Record Librarians.

New officers of the Virginia Hospital Association for next year are: president, Dr. Arthur Hunter Perkins, Riverside Hospital, Newport News; vice president, S. G. Adhizer, Rockingham Memorial Hospital, Harrisonburg; secretary, M. Haskins Coleman Jr., executive director, Richmond Hospital Service Association, and treasurer, W. L. Beal.

New officers of the North Carolina Hospital Association are: president, J. Lyman Melvin, Park View Hospital, Rocky Mount; president-elect, Dr. J. B. Whittington, City Memorial Hospital, Winston-Salem; secretary-treasurer, Sample B. Forbus, Watts Hospital, Durham.

Serving the West Virginia Hospital Association for the coming year are: president, Dr. H. C. Myers, Myers Clinic Hospital, Philippi; president-elect, J. Stanley Turk, Ohio Valley General Hospital, Wheeling; vice president, Dr. Dean L. Horner, Bluefield; secretary-treasurer, Charles E. Runyon, Charleston.

Richmond, Va., was selected as the meeting place for the Carolinas-Virginias Hospital Conference in 1942.

Credit Association to Stress Hospitals

A special session of the annual conference of the National Retail Credit Association will be devoted to a study of credit problems of physicians, dentists and hospitals, according to an announcement last month by L. C. Austin, Menorah Hospital, Kansas City, Mo., who is chairman of this section. The meeting is to be held at the Hotel New Yorker, New York City, June 16 to 19. Among the hospital people who will appear on the program are Murray Sargeant and P. A. Edholmes, New York Hospital, New York City; Frank Van Dyk, Associated Hospital Service, New York City; Emmanuel Hayt, author of "Legal Guide for American Hospitals"; Simon Shapiro, Jewish Hospital, Brooklyn, N. Y., and D. B. Young, manager of the Hospital Credit Exchange, Inc. of New York. More than 2000 credit men and executives are expected to attend the session.

Goldmann Analyzes Five Medical Prepayment Plans

A general discussion of medical prepayment plans and a detailed analysis of five such plans were published last month by the Medical Administration Service, Inc. of New York City.

The author of the pamphlet is Dr. Franz Goldmann and it appears under the title "Prepayment Plans for Medical Care." Other pamphlets in the same series relating to organized medical services are: "General Principles of Medical Organization and Administration" by Dr. Dean A. Clark and Katherine D. Clark, "Membership, Enrollment and Legal Relations" by Perry R. Taylor, C. E., and Martin W. Brown, L.L.B., and "Business Procedures" by Perry R. Taylor.

Financial assistance in the publication of the series was granted by the Goodwill Fund and the Twentieth Century Fund.

Nursing School Becomes Independent

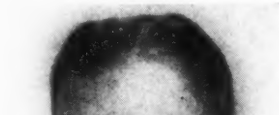
The school of nursing of the University of Michigan Hospitals has been separated from the hospitals and set up as the University of Michigan School of Nursing with Rhoda F. Rettig, former director of the school, as professor of nursing.

SURGICAL INSTRUMENTS DISCUSSED BY FRANK W. WILMARTH

"THERE ARE those who pull a long face, and look positively distressed, when they discuss the surgical instrument situation today," began Mr. Frank W. Wilmarth, Sales Manager, of the House of Weck, at its Brooklyn, N. Y., plant when interviewed.

Mr. Wilmarth went on: "But from our viewpoint, it appears that the current defense operation is really a cause for thankfulness both for the American hospital instrument makers and American hospitals as well.

"From my almost daily contact with a large number of the prominent institutions in the Metropolitan area I think that almost without exception the American hospitals have been anxious to have American-made surgical instruments. The well-posted operating room supervisor is keenly aware of the fact that American-made steel is the finest in the world and that American steel fabricated by experienced craftsmen produces the best instruments.



Frank W. Wilmarth, Edward Weck & Co.

"Consider our own case, as an example. Through the call for defense work, we have been able to quickly—months if not years ahead of ordinary development—tool up, make patterns and dies for a comprehensive range of the so-called 'bread-and-butter' surgical instruments, which we can now offer American institutions at attractive prices.

"Nor is that all as I see it," Mr. Wilmarth resumed, "Weck is able to supply hospitals these instruments now, made in its Brooklyn plant under American conditions, by finest craftsmen in the world finished in either Crodon-Chrome-plated on carbon steel, or in the 'stainless' steel, because the Army and Navy demanded the latter and we had to prepare for that as well as the regular Crodon-Chrome-plated finish.

"If there is a reader of MODERN HOSPITAL interested in learning more about this current development we here at Weck would welcome a call," he concluded.

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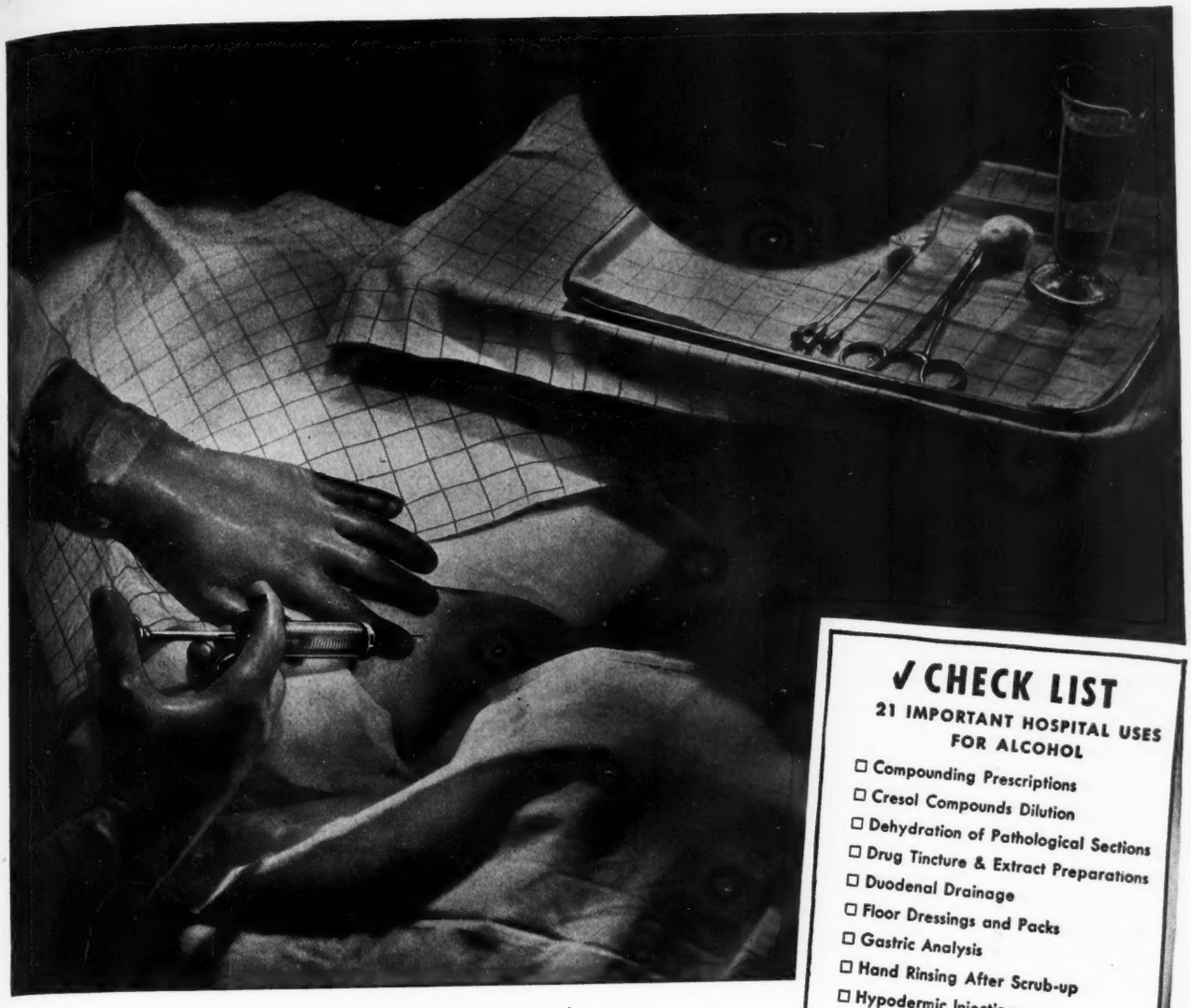

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- ☐ Surgical Soap Preparation
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Names in the News

Administrators

NELLIE GORGAS will assume her new duties as superintendent of St. Barnabas Hospital, Minneapolis, succeeding DR. CLEMENT C. CLAY, on June 15. Miss Gorgas is assistant to Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, and has been connected with the university hospitals for seventeen years. Miss Gorgas is a member of the editorial board of The MODERN HOSPITAL. Doctor Clay, a lieutenant in the U. S. Navy, will join the medical corps for active duty on July 1.

DR. W. L. QUENNELL, medical director of Norfolk General Hospital, Norfolk, Va., presented his resignation, effective June 30, to the board of directors. DR. W. P. EARNGEY JR., present superintendent of Cherokee County Hospital, Gaffney, S. C., will succeed him.

MRS. VIOLA WALTERS BELL, superintendent of Somerset Community Hospital, Somerset, Pa., for the last six years, has resigned. ADELINE DEITZ, assistant superintendent of the institution, has been appointed acting superintendent.

JAMES T. PATE, assistant superintendent of Long Island College Hospital, Brooklyn, N. Y., has been appointed superintendent of Duval County Hospital, Jacksonville, Fla. Mr. Pate will take over his new post on June 1.

DR. J. W. HARTIGAN of Morgantown, W. Va., has been appointed acting superintendent of McKendree Emergency Hospital at McKendree, W. Va. He succeeds DR. NORMAN G. PATTERSON, who resigned. Doctor Hartigan, prior to his appointment, was superintendent of the State Hospital for Insane at Weston.

DR. W. D. MCNARY, superintendent of the Eastern Oregon State Hospital at Pendleton, Ore., has submitted his resignation to the state board of control. Doctor McNary, who has been director of the hospital since it was established in 1912, will act in a consulting capacity until October 1, when the board will appoint his successor. DR. DONALD WAIR, who has been assistant to Doctor McNary, will be the acting executive until a new superintendent is selected.

MRS. HELEN B. ROSS, who has been superintendent of the Community Hospital, Kane, Pa., for the last five years, will assume her new duties as superintendent of Tompkins County Memorial Hospital, Ithaca, N. Y., on June 1.

L. WILLIAM COON, assistant administrator of Meadville City Hospital, Meadville, Pa., has been appointed superintendent of Corry Hospital, Corry, Pa.

LOIS ANNE BLISS, R.N., assistant director in charge of night nursing service of New Haven Hospital and instructor in night nursing education of the Yale University School of Nursing, resigned recently to become superintendent of Franklin Hospital, Franklin, N. H.

DR. ELLA ROBERTS, member of the faculty of the University of Pennsylvania Medical School, has been appointed medical director of Children's Heart Hospital, Philadelphia. Doctor Roberts succeeds DR. O. F. HEDLEY.

ALBERT F. DOLLOFF, assistant director of the New Haven Hospital, New Haven, Conn., since 1931, will leave in the early summer to become superintendent of Laconia Hospital at Laconia,

WHAT THREE TOILET SOAPS CAN HELP MAKE HOSPITALIZATION MORE PLEASANT?

Answer: *Gentle Palmolive, rich Cashmere Bouquet and Colgate's Floating Soap!* The reason is simple. Patients like these soaps. They *enjoy* being bathed with these soaps. And as every doctor knows, even small things count in making a hospital more pleasant. Doctors know the value of catering to the patient's state of mind!

COLGATE'S FLOATING SOAP ADDS A TOUCH OF LUXURY

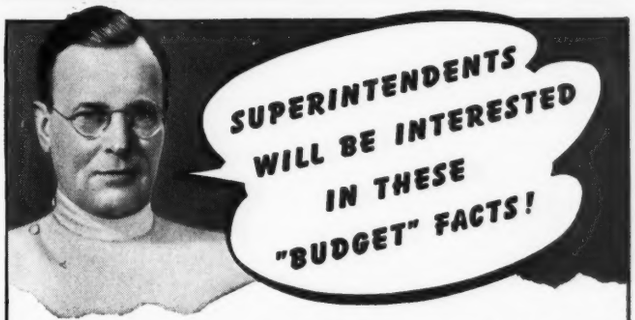
✓ COLGATE'S JUSTLY FAMOUS FLOATING SOAP is another favorite. It, too, is pleasantly fragrant, marvelously gentle to the skin. It's a top-quality soap that gives a luxury of abundant lather in either hot or cold water. Let *your* patients enjoy it!

PATIENTS LIKE PALMOLIVE, THE WORLD'S FAVORITE TOILET SOAP

✓ THIS FRAGRANT, REFRESHING SOAP is the world's favorite. Patients like its gentle lather . . . its wonderful fragrance. Chances are it's the same soap they use at home, which is why it adds to their comfort, helps them feel less "strange." Made with rich Olive and Palm Oils.

CASHMERE BOUQUET DELIGHTS EVERY WOMAN PATIENT

✓ WOMEN ARE PARTICULARLY FOND of Cashmere Bouquet. They love its creamy lather . . . its delicate perfume. What's more, it leaves them feeling dainty, and fragrant long after use. It's a luxurious touch that helps make a hospital more pleasant. A fine, hard-milled soap!



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N. H. Prior to his association with the New Haven Hospital, Mr. Dolloff was associate professor of biology, College of William and Mary, Williamsburg, Va.

Dr. J. R. Colburn, formerly assistant administrator of Alameda County Hospitals, Oakland, Calif., has been called to service as a captain in the U. S. Army Medical Corps, 159th infantry. Dr. W. W. Staedel, who has just completed his year as an intern in hospital administration under Dr. Benjamin W. Black, has been named assistant administrator to succeed Doctor Colburn.

Paul Robinson, formerly superintendent of Neurological Hospital, Kansas City, Mo., who left hospital work about a year ago to enter the photographic supply business, has been called back to hospital service by the U. S. Army and is stationed at an Army hospital near St. Louis.

Karl H. York, formerly credit manager at Columbia Hospital, Milwaukee, has been appointed assistant administrator of the hospital under Joseph G. Norby.

Dr. E. M. Dunstan, superintendent of Parkland Hospital, Dallas, Tex., has been granted a leave of absence for a year's service as a major in the Army Medical Corps. R. C. Nye will be acting superintendent of the hospital during Doctor Dunstan's absence.

Department Heads

Margaret H. Groneweg, who has been associated with Jennie Edmundson Memorial Hospital, Council Bluffs, Iowa, for the last fifteen years, has resigned to accept a position with the Associated Hospitals Service, Inc., of western Iowa.

William Gray, R.Ph., head pharmacist of Presbyterian Hospital, Chicago, for thirty-five years, retired on March 1. Malcolm Hutton, R.Ph., former assistant pharmacist, has been appointed Mr. Gray's successor. Franklin B. West has been named assistant pharmacist under Mr. Hutton.

Miscellaneous

Ada Belle McCleery, recently retired administrator of Evanston Hospital, Evanston, Ill., has been named a trustee of Delnor Hospital, St. Charles, Ill.

Leroy C. Vincent, formerly promotional director for the Associated Hospital Service of Philadelphia, joined the staff of the A.H.A. Hospital Service Plan Commission on May 1 for a period of five months, to assist in outlining a comprehensive program of public education for presentation by the commission to the representatives of approved plans in Atlantic City in September.

Dr. J. R. McGibony has been appointed director of health of the U. S. Indian Service, according to an announcement made recently by Harold L. Ickes, secretary of the interior. Doctor McGibony succeeds Dr. James G. Townsend, who has been made director of industrial hygiene for the National Institute of Health.

Harold S. Barnes, superintendent of Latter-Day Saints Hospital, Salt Lake City, Utah, has resigned to accept an executive position in the research and production laboratory field.

Ralph W. Jordan, secretary of the Ohio Hospital Association, and Mrs. Lucille Brick, assistant secretary, have resigned their positions with that organization to devote their entire time as director and associate director, respectively, of the Central Hospital Service.

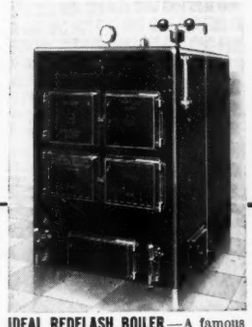
Dr. Irving S. Cutter, dean of Northwestern University Medical School, will retire on June 1 and will be succeeded by Dr. J. Roscoe Miller, assistant dean of the school. Doctor Cutter, however, plans to continue as superintendent of Passavant Memorial Hospital, Chicago, and as health editor for the Chicago *Tribune*.

Deaths

Dr. Ralph P. Folsom, superintendent of Hudson River State Hospital, Poughkeepsie, N. Y., died at the age of 65. Doctor Folsom had been in the state hospital service for thirty years.

First Aid for Heating and Plumbing in Hospitals

AMERICAN HEATING EQUIPMENT & "Standard" PLUMBING FIXTURES



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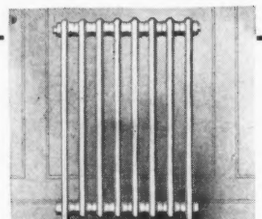

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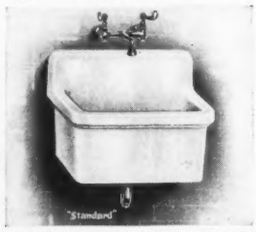

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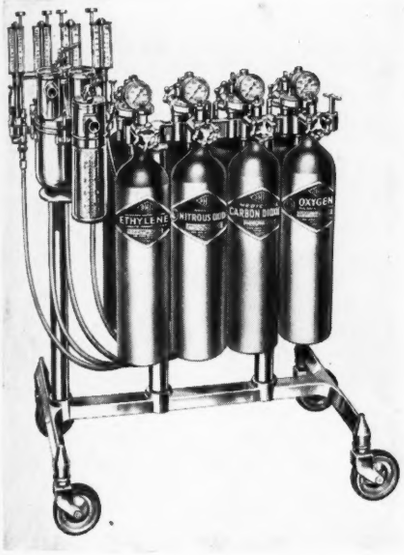

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for its dependability, simplicity, accuracy of control and range of usefulness.

The Kinet-o-meter gives both doctor and anesthetist the anesthesia equipment that meets their requirements and which is adequate for every emergency that may arise. With this apparatus each gas is controlled and delivered independently. Any gas may be administered separately or in combination with any or all other gases. The proper hooking of apparatus and gases is so clearly designated that error is practically impossible.

Other features that make the Heidbrink Kinet-o-meter so much preferred are its economical operation, its sturdy construction and its flexibility of adjustment where the operating table must be tilted to extreme angles.

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Orde Resigns Secretaryship of British Hospitals Assn.

R. H. P. Orde, honorary secretary of the British Hospitals Association since 1929, has announced his resignation from that position, which he has filled with distinction.

Mr. Orde is retiring because of continued ill-health and the very heavy demands that the position makes under war conditions. It was largely due to Mr. Orde's enthusiasm, says an editorial in the *Hospital,* that the Voluntary Hospitals Commission of the British Hospitals Association ("Sankey" Commission) was set up and he undertook the burdensome but most important office of honorary secretary of the commission. He was also joint secretary of the United Kingdom Council of the International Hospitals Association and lecturer on administration to the Royal College of Nursing.

J. P. Wetenhall has been appointed to succeed Mr. Orde, coming to the position from the West End Hospital for Nervous Diseases.

Ohio Munitions Plant Explodes

An explosion in a local munitions plant recently required the Warren City Hospital, Warren, Ohio, to hospitalize more than 100 emergency cases.

Buerki Goes to Pennsylvania

Dr. R. C. Buerki, administrator of the University of Wisconsin hospitals and secretary of the medical school faculty, will become dean of the Graduate School of Medicine and director of hospitals of the University of Pennsylvania on October 1. Dr. George H. Meeker, present dean, is retiring. Doctor Buerki will have charge of University Hospital, Graduate Hospital and Orthopedic Hospital. He is a past president of the A.H.A. and the A.C.H.A., is chairman of the Tri-State Hospital Assembly and member of the editorial board of The Modern Hospital.

Nebraska Association Elects Officers

New officers were elected recently by the Nebraska Hospital Association. Ursula Penner Frantz, as president, succeeds Dr. C. A. Lutgen. Her hospital is the Mennonite Deaconess at Beatrice. Rev. O. F. Keller of Lutheran Good Samaritan Hospital, Columbus, is president-elect. Dr. Francis J. Bean of the University Hospitals, Omaha, is secretary-treasurer and Sister Mary Consolata of St. Mary's Hospital, Columbus, is a new trustee. It was decided to hold a one day meeting of the association each year within the state for the discussion of legislative affairs and other strictly state business.

Santa Monica to Combine With California Hospital

Preliminary plans have been approved for incorporating the Santa Monica Hospital, Santa Monica, Calif., with the California Hospital, Los Angeles, on Jan. 1, 1942, converting the present profit corporation into a nonprofit institution.

The transfer will be in the form of a gift, in which Dr. William S. Mortensen and Mrs. August B. Hromadka will cooperate to create a memorial for the late Dr. August B. Hromadka and Doctor Mortensen.

The main structure of Santa Monica Hospital was completed in July 1926 and is completely equipped as a modern class A hospital.

Southwestern Institute Planned

The first Southwestern Institute for Hospital Administrators is to be held at Southern Methodist University, Dallas, Tex., November 17 to 28. The institute is sponsored by the A.C.H.A., S.M.U., the Texas Hospital Association and the Dallas County Hospital Council. J. H. Groseclose of the Methodist Hospital, Dallas, is director; A. C. Seawell of City-County Hospital, Fort Worth, and Gerhard Hartman of the A.C.H.A. are associate directors.

There's a real savings story in these stylish, cheerful walls

Note how the attractive stork design—executed in Linowall—adds a pleasant touch to the nursery of the Newton Memorial Hospital, Winfield, Kansas. You will find a generous assortment of plain, marble, wood, and burl effects in this linoleum-like wall covering. Write now for a free copy of Modern Walls for Modern Buildings.

THEY'RE Armstrong's Linowall—the linoleum-like wall covering that costs only about half as much as other permanent materials. This modern, decorative material can be quickly and inexpensively installed over any sound plaster wall or approved wallboard. But low first cost is only the beginning of the economies that Linowall brings you.

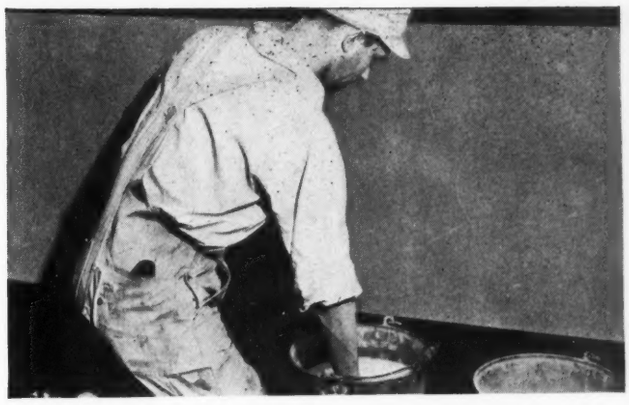
The real year-in-and-year-out savings come from low-cost maintenance. Armstrong's Linowall is truly washable—and costly refinishing is never necessary! A damp cloth and mild soapsuds quickly remove fingerprints, smudges, and ordinary stains. Furthermore, the rich colors do not wear off . . . they run right through to the fabric backing. Because it is flexible, Linowall can be formed smoothly around inside and outside corners, making cleaning even easier and giving a streamlined, modern appearance. Linowall is extremely durable, too. Its resilience makes it highly resistant to denting.

For complete facts about this new money-saving material, write now to Armstrong Cork Company, Floor Division, 1231 State Street, Lancaster, Pennsylvania.

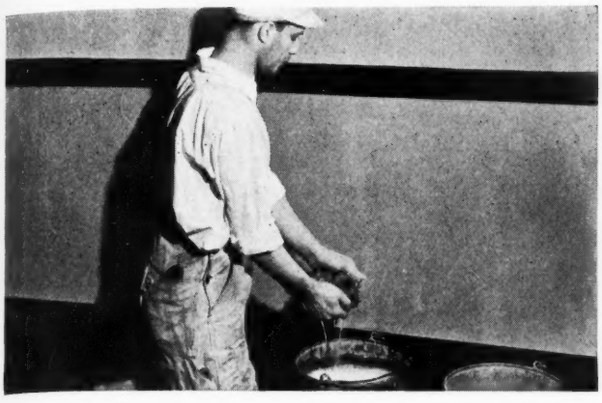
ARMSTRONG'S LINOWALL

Made by the makers of Armstrong's Linoleum

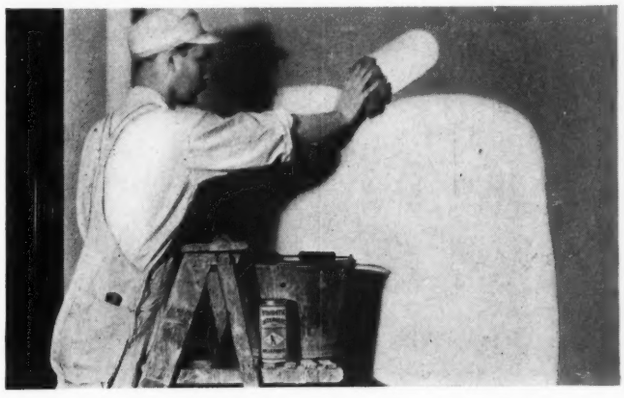
HERE'S HOW TO MAKE AN OLD ROOM NEW



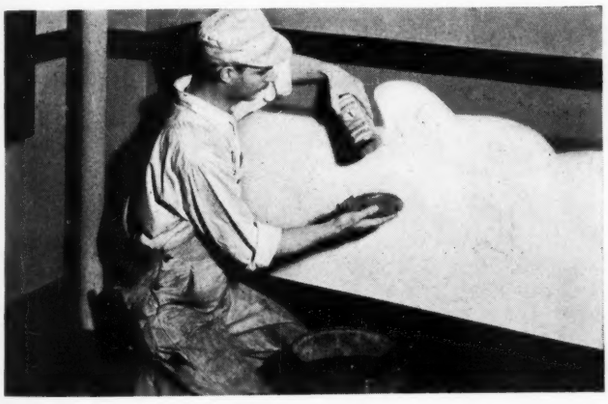
1—Use two pails—one with Wyandotte Detergent in solution (half-pint to a gallon of water); the other with plain water for rinsing.



2—Use a sheep's wool sponge. Squeeze excess solution from the sponge to avoid dripping, then apply, working from the bottom to the top.



3—Clean but a small portion at a time. On walls, wash from the bottom up to avoid streaks. After washing rinse with a sponge and clean water.



4—Where more than ordinary soil is found, sprinkle a little dry Wyandotte Detergent on sponge and clean the soiled surface.

• That's how Wyandotte Detergent goes to work on walls. It is equally as effective on floors, ceilings and as a general maintenance cleaner.

Here are two other Wyandotte Products that you will want to know about: Wyandotte Industrial Alkali for low-cost drain cleaning. (Dissolve 1 pound in 2 quarts of hot water and pour down drain.)

Wyandotte Steri-Chlor, a chlorine germicide and deodorant in dry form, completely soluble. The solution may be used as a rinse; applied with cloth or mop; or sprayed with a gun.

For demonstration of *any* Wyandotte product, get in touch with your local Wyandotte Service Representative.

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Ohio and Texas Consider Medical Plans

Two state enabling acts for the formation of medical service plans to parallel the development of hospital plans have recently been considered by state legislatures. In Ohio an act permitting such plans has been passed and in Texas a bill has been introduced into both the house and senate. In each instance the state medical association has been active in promoting the legislation.

Would Rehabilitate Rejected Draftees

At the final session of the annual conference of State and Territorial Health Officers, the committee on hospital and medical care urged that Congress provide funds and authority to the U. S. Public Health Service to provide for the rehabilitation of men found unfit for military service. The committee reported that 42 per cent of all draftees are rejected for military service because of physical defects, many of which are correctable.

Cornell Gets Large Grant

Cornell University Medical College, New York City, has received an appropriation of $600,000 from the Rockefeller Foundation for the endowment of the department of public health and preventive medicine, according to Dr. William S. Ladd, dean of the college.

Two Southern Institutions Enlarge Nurses' Residences

Construction work on the $400,000 six story nurses' home for Hotel Dieu, New Orleans, is under way. When completed, the building will accommodate 200 nurses and the present nurses' home will be remodeled for patient accommodations and interns' quarters.

Construction also has begun on the $175,000 addition to the nurses' home of Baptist Hospital, Memphis, Tenn. When completed, the eight story structure will accommodate 100 nurses.

Sharp Gain in Home Nursing Group

There was an increase of more than 40 per cent in the number of women taking instruction in home nursing from the American Red Cross, according to a report by Mary Beard, national director of Red Cross Nursing Service, presented at a meeting of agencies interested in this field in Washington recently. Last year more than 63,000 certificates were issued for completion of the course.

Nurse Practice Digest Is Out

A digest of the nurse practice acts and board rules in effect on Jan. 1, 1940, in 48 states, the District of Columbia and the territories of Puerto Rico and Hawaii was published last month by the American Nurses' Association.

Chicago Council Studies Ratio of Beds

The ratio of beds in single rooms, 2 bed rooms, 3 bed rooms, 4 bed rooms and in rooms with 5 or more beds was recently determined for the Chicago hospitals in a study by the administrators' section of the Chicago Hospital Council. Of 4811 general adult beds, 1609 were in single rooms, 1372 were in 2 bed rooms, 267 were in 3 bed rooms, 534 were in 4 bed rooms and 1029 were in rooms with 5 or more beds. In addition, these hospitals had 1233 obstetric beds, 987 children's beds, 1280 bassinets, giving a grand total of 8311 accommodations.

Medical Center Commission Appointed

Chicago's plan for a vast West Side medical center has been brought considerably nearer realization by passage by the Illinois legislature of a bill authorizing a commission to handle the matter. The commission is to be composed of one member each to be named by the governor, the president of the Cook County board, the mayor of Chicago, the trustees of the University of Illinois and the Chicago park district board. The University of Illinois and other universities are cooperating in the plan as are Presbyterian Hospital, Cook County Hospital and many other institutions now located in the neighborhood.

APPEARANCE and SERVICE that Belie Their Cost....

Only those who are familiar with Hill-Rom methods of specialization in the manufacture of fine furniture for the modern hospital would believe it possible to completely furnish a room like this at such reasonable cost. Many years of experience and a large volume of business permit the use of the finest furniture woods, accessories, furnishings, and the highest order of craftsmanship, well within the budget of any hospital. Write for catalog illustrating numerous room ensembles, reproduced in full color. It's yours for the asking.

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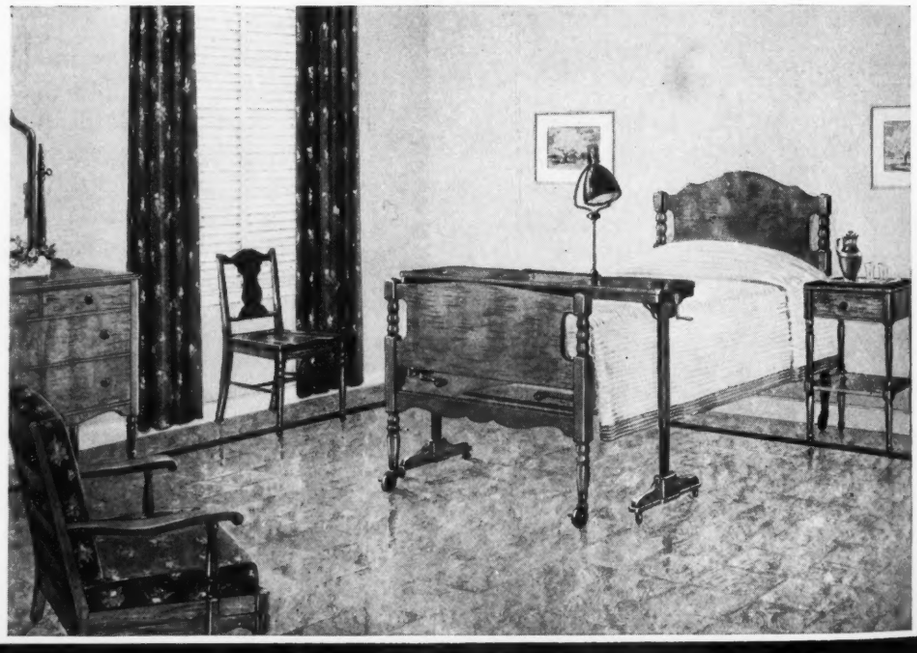

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FOR THE MODERN HOSPITAL

We Asked a Leading Obstetrician

"WHAT SHOULD WE TELL MOTHERS ABOUT INFANT FEEDING?"

HERE IS WHAT HE TOLD US TO SAY

EXPECTING A BABY?

● Ask your doctor about breast feeding, especially during early weeks of infancy. Take his advice on supplementary feeding, particularly about cleanliness. Regular medical care and advice on nutrition can speed development and improve baby's health.

HYGEIA NURSING BOTTLE AND NIPPLE

SAFER...because easier to clean

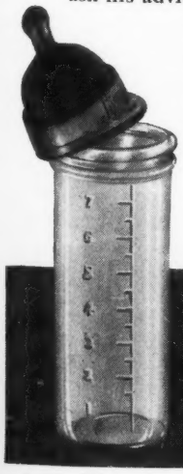
Also in HEAT RESISTANT GLASS

See Your Doctor Regularly

EVERY HYGEIA ADVERTISEMENT SAYS "SEE YOUR DOCTOR REGULARLY" — "ASK YOUR DOCTOR'S ADVICE"

● Hygeia has always recognized the vital importance of pre-natal and post-natal care in helping to reduce mother and infant mortality.

Now, in its 32nd year of advertising, the number of Hygeia advertisements to appear in national magazines is practically doubled over last year. More readers than ever before will be told to see a doctor regularly, to ask his advice on infant feeding.



We leave it to you to prescribe breast-feeding or artificial feeding according to individual requirement. If the latter, we know you will want to recommend HYGEIA, the most sanitary and efficient nursing bottle and nipple.

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that buy up to a standard, not down to a price

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Wherever purchasing agents buy wisely for long-term service and true economy, GORHAM is their choice.

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Books on Review

FUNDAMENTALS OF ADMINISTRATION FOR SCHOOLS OF NURSING. *Report of the Committee to Study Administration in Schools of Nursing. New York City: National League of Nursing Education,* 1940. $2.

Probably no book on nursing has been more timely than this. None is more needed. In its clear-cut, logical presentation of the functional analysis of administration, it portrays the functional elements of a school (purpose, activities, personnel, physical facilities, time and control) and the nature of the administrative process regulating these elements, involving as it does the curriculum, teaching, personnel, students, other facilities, financial support and organizing.

Finally, a summary of basic concepts and principles is included, together with a good appraisal of three school situations. Nine excellent figures of organization facilitate greatly an appreciation of the text, as do also well-chosen analogies.

This volume should stimulate wholesome discussion of many topics, among them that of placing the school of nursing committee in an advisory capacity. The book is especially recommended to boards of trustees and to professional personnel.—KATHARINE J. DENSFORD, R.N.

HOSPITAL MANAGEMENT AS A CAREER. *Chicago: Institute for Research,* 1940. *Pp.* 17. $1.

This brochure is intended to serve as an introductory guide to persons planning to enter the hospital field.

A great deal of attention is given to a descriptive account of the unique features of hospital administration as distinguished from other managerial positions. The statement stresses the need for the administrator to be fully conversant with the nature of an extensive variety of fields.

Perhaps the most interesting feature is the statement of the advantages and disadvantages of a career in hospital administration. The report points out, however, that the advantages, by and large, outweigh the disadvantages, particularly for the administrator who is gaining in experience and reputation and feels that the work gives him a way to serve the needs of the community and to increase the sphere of the hospital's usefulness.—GERHARD HARTMAN.

HOSPITAL FORMULARY AND COMPENDIUM OF USEFUL INFORMATION OF THE UNIVERSITY OF CALIFORNIA. *Prepared by a Committee Composed of Members of the University Teaching Staff and Members of the Hospital Professional Staff. Berkeley, Calif.: University of California Press,* 1941. *Pp.* 270. $2.

This text is a sharp departure from the usual hospital formulary insofar as it embodies dissertations and expositions on a wide variety of subject matter pertinent to hospital medical and diagnostic practices. It would appear that the book was designed to include under one cover most standard specialized procedures of the nature indicated for interns, nurses and technicians as well as practicing physicians and pharmacists. The contents ranges from a well-concentrated treatise on prescription writing to a discourse on the procedures of a well-baby clinic and from a dental formulary drug list to a table of international atomic weights.

The book is beyond doubt a compendium of useful information and, if duplicated, will lead to a new interpretation of the term "hospital formulary."—DONALD A. CLARKE.

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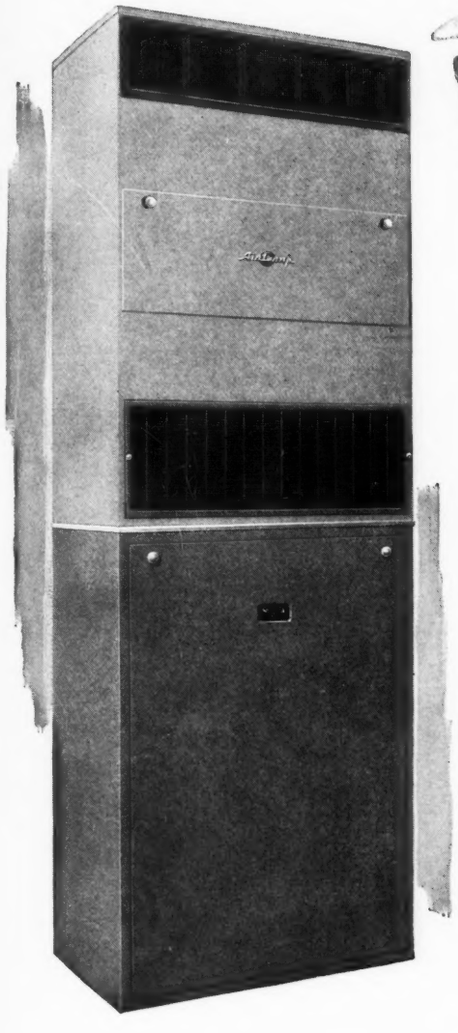

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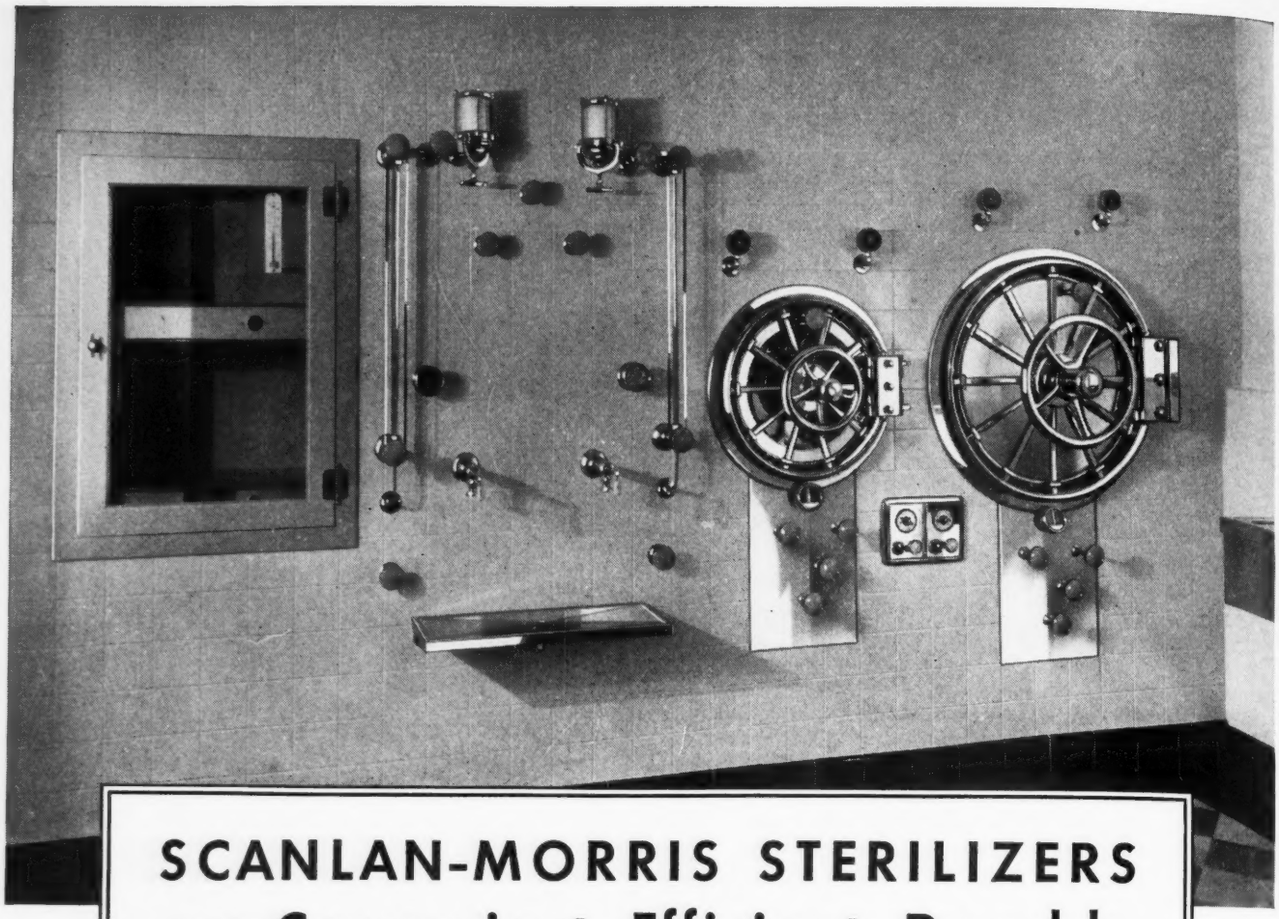

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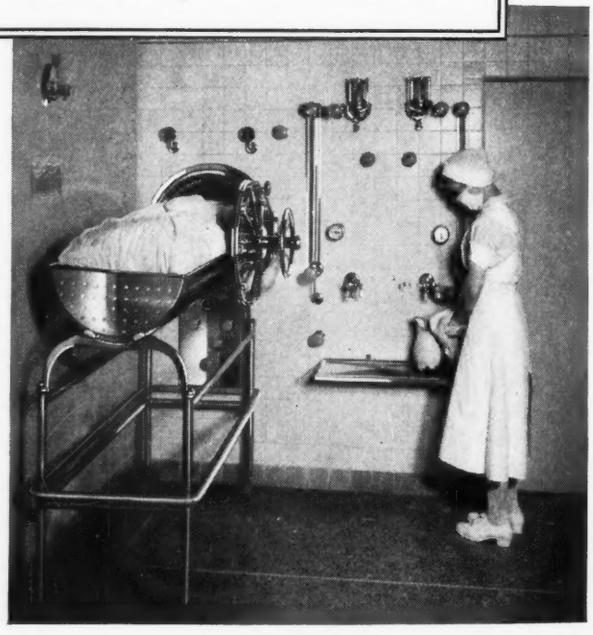
Our engineering and planning department offers its services without obligation in the selection and arrangement of sterilizers that will meet specific requirements most efficiently and most economically. Ask for our Sterilizer Planning Manual.

Above. Scanlan-Morris autoclaves, water sterilizers, and solution warmer, recessed in wall, at St. Anthony's Hospital, Chicago, Illinois.

Right. Scanlan-Morris autoclave and water sterilizers at LaFayette Home Hospital, LaFayette, Indiana.



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OPERAY LABORATORIES — Surgical Lights

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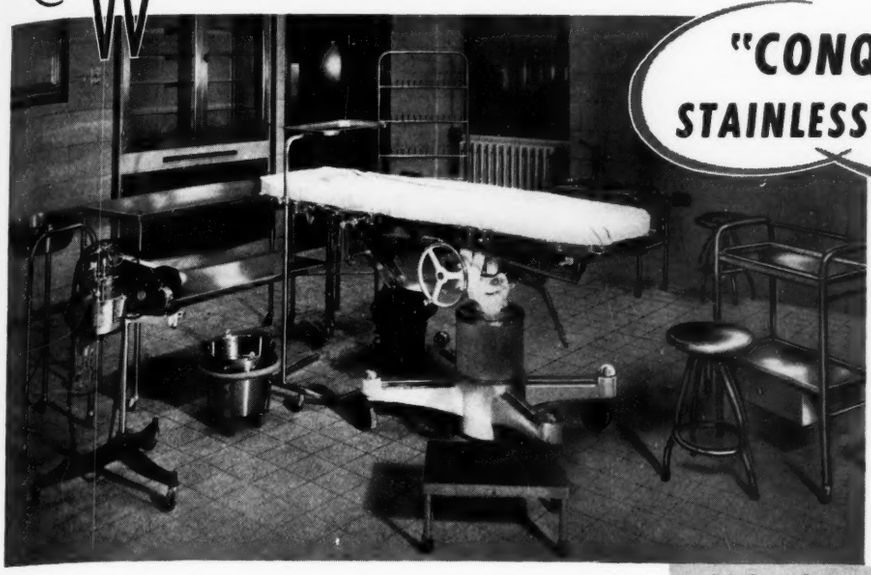
Where Hospitals Show Steady Growth...You'll find

"CONQUEROR LINE" STAINLESS STEEL EQUIPMENT



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Wilmington, Del.

• Recently completed buildings at the Delaware Hospital equipped by "CONQUEROR" include five major operating rooms, two delivery rooms, an accident ward and a nursery furnished completely with Stainless Steel bassinets. In addition are numerous wheel stretchers, portable chart carriers, dressing carts, linen hampers and nurses' chart desks.

WITH just a few beds in 1890 to over 400 beds and bassinets today—is but a bare outline of the development of this hospital. In between is a story of continuous growth based on a community service which has never lost sight of the highest standards of the medical and nursing professions. Progressive and alert to the demands of the times, the Delaware Hospital has been constantly adding new equipment with which to improve the care of the sick in every possible way.

It is a coincidence that the manufacturers of "CONQUEROR" equipment have also experienced their development over the same half century. But it is no mere coincidence that the same devotion to the highest standards of medical science has produced equipment which is today approved and used by the country's leading institutions. Every item, built to rigid specifications, bears the assurance of perfect and efficient performance, plus the ultimate economy inherent in its long life — for there are no replacement costs with practically indestructible "CONQUEROR" Stainless Steel Equipment.

CONSULT US: *Let us show you how "CONQUEROR" equipment can improve the service and efficiency of every department in your hospital. Room layouts, specifications and prices furnished without any obligation whatsoever. Write now for catalogs illustrating and describing our complete "CONQUEROR LINE" of Hospital Equipment.*

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2. **STRENGTH:** All heavy material—no thin metal is used.
3. **DURABILITY:** Only genuine, non-magnetic 18-8 grade Stainless Steel to assure corrosion-resistance—no inferior type is used.
4. **CLEANLINESS:** All joints circumferentially welded, fully rounded and ground smooth.
5. **SAFETY:** No injury-provoking sharp edges or crevices.
6. **ATTRACTIVENESS:** Modern, streamline design and highly polished surfaces—not just a grind finish.

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Major Operating Room: *One of five operating rooms furnished with "CONQUEROR" Stainless Steel equipment. It is interesting to note that, unlike ordinary furniture, "CONQUEROR" equipment is made completely, not just in part, of Stainless Steel. Included in the items illustrated are Baker Solution Stand, Howard Instrument Table, Kellogg Sponge Rack, Chadwick Two-Drum Stand, Clifton Revolving Stool, Johnston Anesthetist's Table, Kent Foot Stool, Lexington Kick Bucket and Walker Instrument Stand.*
—Plate No. 4052

Delivery Room: *In every department of the hospital, "CONQUEROR" Stainless Steel equipment lends itself to such practical, orderly arrangements as pictured above. Units used are similar to these shown in the Operating Room, including the Snyder Double Solution Stand.*
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are the most serviceable and economical all-purpose waterproof fabrics money can buy.

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- **May be boiled, repeatedly autoclaved and safely stored.**
- **Highly resistant to alkalies, oils, acids, alcohol, urine, body fluids.**

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No. 8609 Extra heavy, double coated, ivory	45"
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No. 6826 Horco Rayon, ivory	40"

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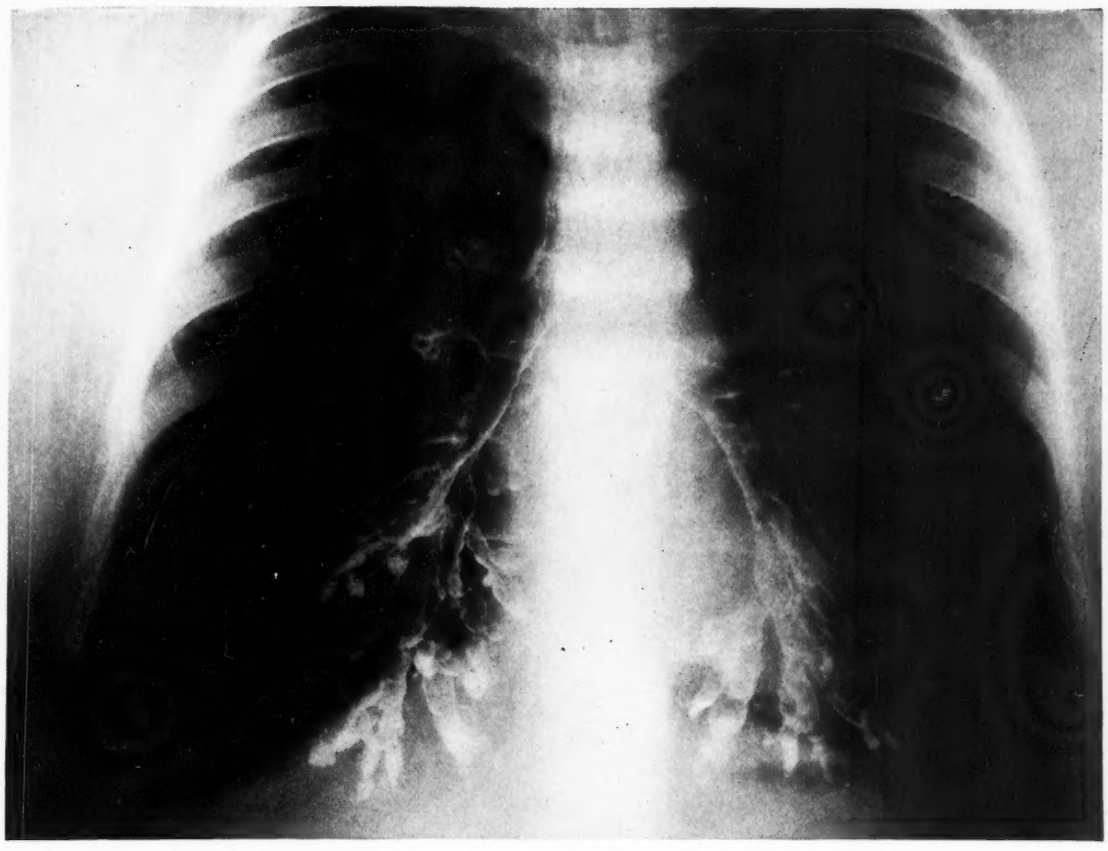

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Representatives in All Principal Cities of the U. S. and Canada

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HOSPITAL SOLVES ODOR PROBLEM WITH **DOREX** ADSORBERS!

Odors, so baneful to morale and retarding to recovery in many cases, can now be eliminated from hospital wards and private rooms through use of Dorex Odor Adsorbers. In place of distressing smells, patients and attendants breathe clean, fresh air. The letter at the right from Bethesda Hospital, Cincinnati, tells of successful removal of the odors accompanying even such cases as carcinoma and gangrene. Other hospitals tell how Dorex has eliminated odors

J. A. Diemann, Superintendent

CHRISTIAN COLDER FOUNDER

BETHESDA HOSPITAL

OAK STREET and READING ROAD

Albert N. McGinnis, Business Manager

CINCINNATI, O.

April 5, 1941

W. B. Connor Engineering Corporation
Dorex Division
114 East 32nd Street
New York, New York

Gentlemen:

We have always had, along with all other hospitals, the problem of elimination of unpleasant odors. We read in a trade paper of your Dorex equipment and the claims made for it. We wrote you and you had your local representative call on us.

We had two of your Dorex outfits placed in our hospital on trial. We gave them an extremely severe test in connection with such offensive conditions as carcinoma, gas gangrene bacilli infection, diabetic gangrene, and so on. They proved very efficient and we purchased the outfits and have had them in use constantly ever since.

We used them in the summer time with the room door open into the corridor, and have also used them in wards of four or five beds where only one patient was suffering with this offensive odor, and in every case Dorex took care of the condition with entire satisfaction.

In one case where a patient, in our opinion, had gotten along far enough not to require the Dorex as much as another man in the hospital, the first fellow refused to give it up and threatened to be transferred to another hospital if we took the Dorex away from him.

You are at liberty to use this letter in any way you wish.

Yours very truly,

BETHESDA HOSPITAL

Business Manager

McG:WT

caused by lung abscesses, puerperal infections and osteomyelitis. They report that appetites improve with the introduction of a Dorex Adsorber and recovery is considerably aided. Outlook and reaction of patients are strengthened. Hospital Laboratories are also protected from smells by Dorex equipment.

A circulating fan draws contaminated air through the Dorex Adsorber where it passes through a bed of coconut shell carbon, which adsorbs, or condenses and holds, the gases and odors. Moderate in cost, Dorex Units are inexpensive to maintain.

Dorex Adsorbers have a long life and can be put on a *self-liquidating basis.* Write for Bulletin M-6 giving complete information.

Also ask us for the name of the hospital and sick room supply service nearest you which has Dorex Equipment for rent.

"WORKS LIKE A GAS MASK"

DOREX

Reg. U. S. Pat. Off.

ODOR ADSORBERS

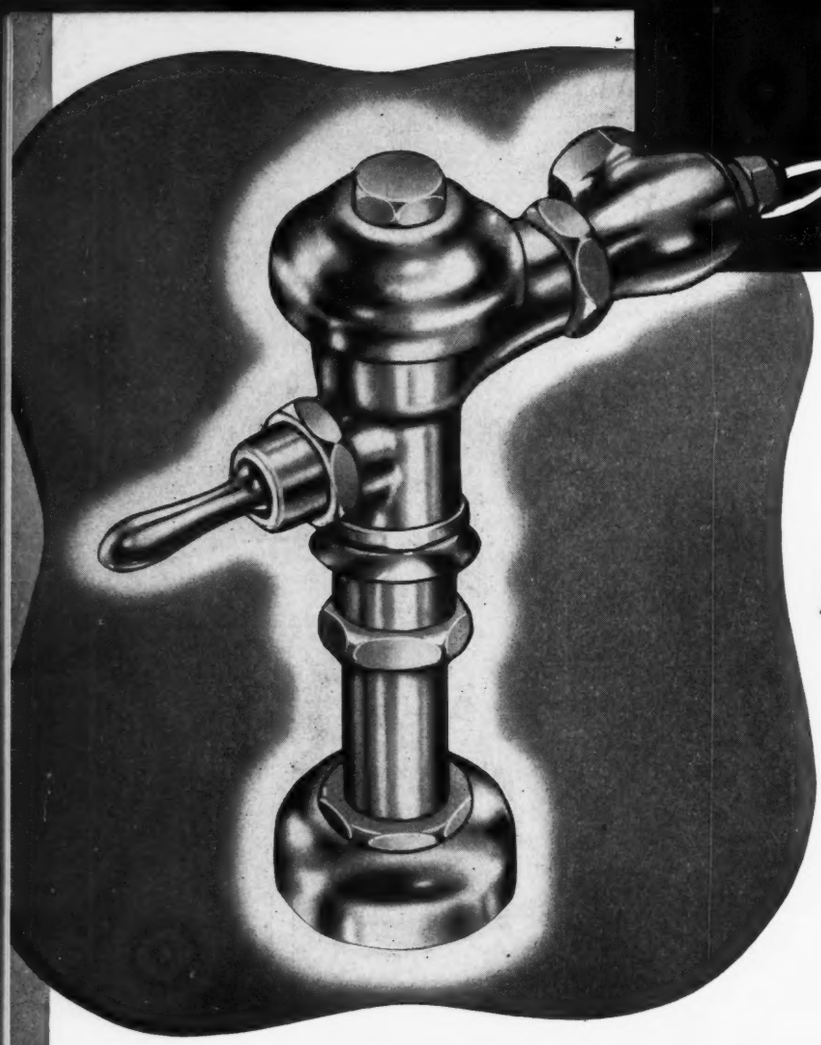
DOREX DIVISION

W. B. CONNOR ENGINEERING CORP.

114 East 32nd Street — New York, N. Y.

Sales Representatives in principal cities

In Canada: Arthur S. Leitch Co., Ltd., Toronto



Are SLOAN

Take University of

Here is the testimony of 27 years continued use, year in and year out. Some of the original valves are still in service, a remarkable record for hand-operated public equipment subjected to severe daily use—and abuse.

Do you wonder that SLOAN Flush Valves were installed exclusively throughout the great building program of the University—that SLOAN is standard equipment today on Chicago's campus, as it was a quarter century ago?

HERE ARE THE FACTS

1 Sloan *enduring satisfaction* can be verified by you in *your* locality. Installations fifteen, twenty or twenty-five years old are common to every section of the country and to every type of building. We will gladly supply a list of old installations in your city which you can personally inspect.

2 Sloan *economy* is a matter of record. Ask the owner or manager of *any* Sloan-equipped building. Sloan Flush Valves cost but ½c to 1½c per valve per year to maintain. Entire installations in service for years without being touched are constantly reported.

3 Sloan Flush Valves save water *all* the time because their adjustment is *permanent*, assuring a uniform flush at every operation, and because the original Sloan "can't-be-held-open" feature limits the flow to one complete flush, regardless of whether the handle is held or released.

That's Why . . . In schools or hospitals, in office buildings or hotels, in institutions or factories, in apartments or public buildings, you'll find the vast majority of flush valves are SLOAN. Indeed—*throughout the entire building field more SLOAN Flush Valves are sold than all other makes combined.*

ENJOY SLOAN MECHANICAL ADVANTAGES —PLUS SAFETY AND UTTER QUIET

It's easy to have security and silence when you specify SLOAN. No Sloan Flush Valve can cause water contamination through back-syphonage when it is equipped with the Sloan Vacuum Breaker—the *first* preventive to be approved by the authoritative National Plumbing Laboratory.

And flush valves can be *whisper*-quiet, inaudible through closed bathroom doors, if they are Sloan *Quiet-Flush.*

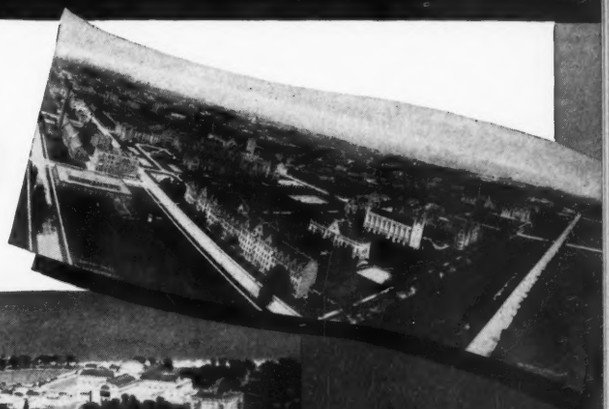
You can enjoy these two added benefits at a cost so slight that economies of Sloan operation will soon repay their original cost. (In many localities vacuum breakers are required by law. Naturally, Sloan is approved everywhere by all testing and regulatory bodies.)

NATIONAL PLUMBING ACCEPTED LABORATORY

SLOAN

AN FLUSH VALVES *as Good as We Say!*

sity of Chicago for Example



The University of Chicago

. . . as it looked 27 years ago and as it looks today. The older photograph above was taken from a box kite. The camera was hauled up a kite string and as the camera reached the kite it ran over a catch which tripped the shutter and exposed the plate.

In the modern photo 33 of the imposing new buildings are SLOAN equipped.

It Costs No More to Have the Best

The perfection of fine workmanship, the unceasing research for improvement, and the advanced engineering of the world's outstanding flush valve organization are yours at no extra cost. The economies of large production make possible the popularity and perfection of Sloan valves. You pay no premium for premium quality when you insist on SLOAN.

Help Defense by Early Planning

The responsibility of furnishing the nation's defense requirements falls most heavily on Industry's leaders. The Sloan Valve Company is no exception. Orders for the vast Army and Navy program receive preferred attention—as you would expect and demand. Schedule your wants for Sloan Flush Valves as far in advance as possible to insure on-time shipments.

***Plan with us now for future needs. Catalogs, literature, piping tables, and skilled engineering assistance are at your service without obligation. Call our nearest representative or write us* now.**

SLOAN VALVE COMPANY • 4300 WEST LAKE STREET, CHICAGO

N *Quiet Flush* VALVES

DEFENSE AND THE FUTURE...

Copy of Letter to users of Products of The International Nickel Company, Inc.

The International Nickel Company, Inc.

EXECUTIVE OFFICES: 67 WALL STREET

ROBERT C. STANLEY,
PRESIDENT

New York, April 17, 1941.

Dear Sir:

Our plants, in common with those of most of America's industrial units, are working at their peak on defense production. In spite of this, hardship is being inflicted upon many consumers of our products who in the past have aided us in building a great business, and upon whom we must depend for our future success.

As this letter is written the monthly production rate of The International Nickel Company of Canada, Limited is already 20% above last year; three times that of 1929 and four times the peak rate of the last war. Its facilities have been increased to supply current defense demand and further increase in output will be available this year.

Upon the conclusion of this devastating war the future success of your business and ours will depend in large measure upon the retention of the good will of our customers. Any effort we can make, not conflicting with our full support of the defense program, should be directed toward this vitally important objective.

To this end we wish to offer our services especially to those customers whose requirements cannot for the moment be filled. One practical means of rendering such service is to offer you the assistance of our technical staff in solving problems of material arising from the temporary lack of nickel.

Our problems are complex and constantly changing and can only be solved through cooperation. As we see it, a large part of the solution lies in making clear the situation which we face. Your help and advice will be of invaluable assistance. It is our purpose to follow this letter with a personal call from one of our representatives, if you so desire, who will discuss with you in more specific detail our mutual problems.

Yours very truly,

RCS:JJS

PRESIDENT.

THE NEW DELAWARE HOSPITAL, WILMINGTON, DELAWARE

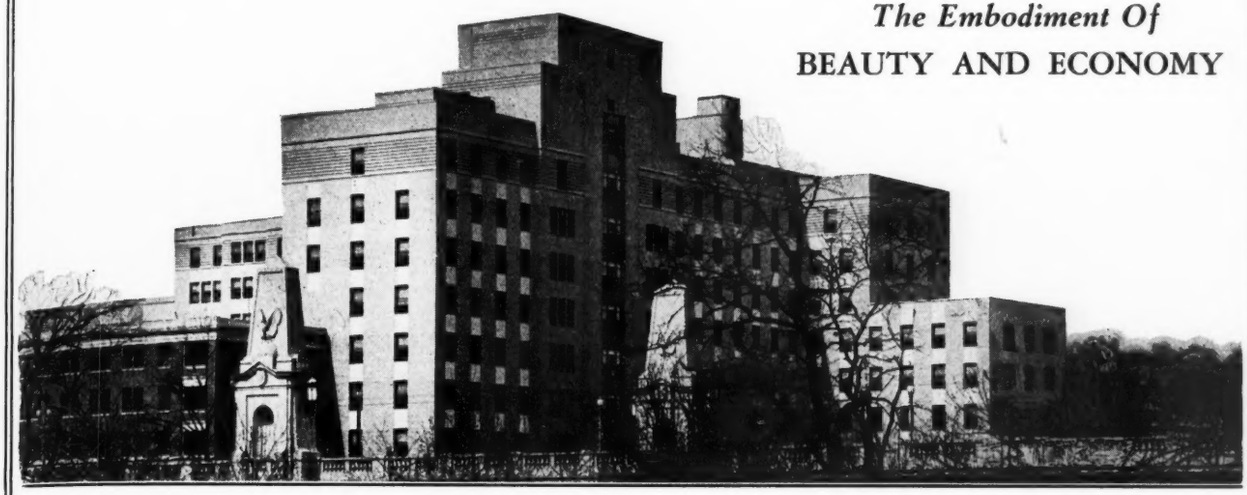
SELECTS

WASHABLE **FABRON** *SUN-FAST*

FABRIC WALL COVERING

The Embodiment Of

BEAUTY AND ECONOMY



Architects
Massena & DuPont, Inc.
Wilmington, Delaware

General Contractors
Turner Construction Co.
Philadelphia, Pa.

The use of FABRON wall coverings in all patients' rooms, wards, and nurseries of this outstanding new hospital has insured the solution of 3 definite problems.

C. A. Hume
Superintendent

- **The interiors have been given an atmosphere of friendliness and comfort through the introduction of restful FABRON hospital patterns and soft-colored semiplain textures.**
- **The periodic expense for redecoration, which plagues every superintendent has been disposed of for many years to come.**
- **The maintenance of walls and ceilings has been reduced to its greatest possible simplicity. An occasional cleaning will restore to these surfaces their original freshness.**

If you do not have a consultant, we offer the services of our Hospital Department, which for years has specialized in solving decorating problems.

Color schemes, cost estimates, and expert advice on wall and ceiling decoration are submitted cost free for your consideration.

fabron

FREDERIC BLANK & CO., INC.
230 Park Ave. New York, N. Y.

FREDERIC BLANK & CO., INC. M.H. 6-41
230 Park Ave., New York, N. Y.

Please send samples and more information about Fabron. Also please indicate approximate cost of material for a room of following size: WIDTH.....LENGTH.....HEIGHT.....

DOORS.....WINDOWS.....EXPOSURE.....

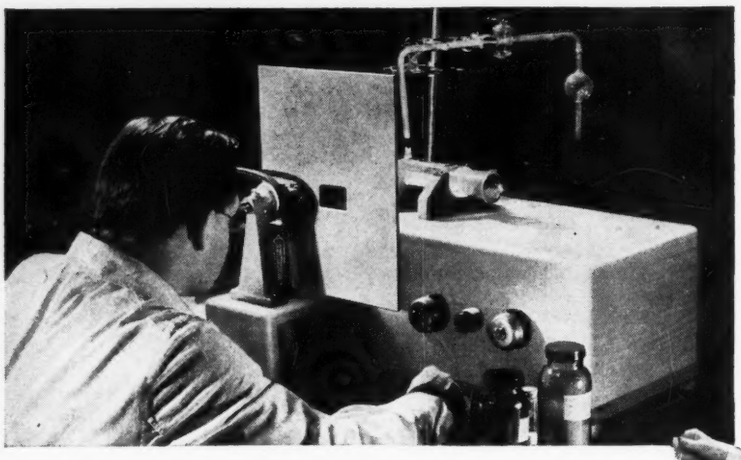
Name.....

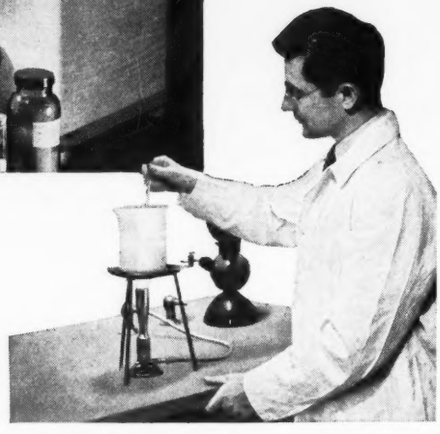
Hospital.....

City.....State.....

HOW YOU PROFIT FROM THE

"UNSEEN" IMPROVEMENTS IN PATTERSON X-RAY SCREENS!





X-RAY SCREEN RESEARCH to be successful can never be spasmodic. It must be carried on, day in and day out, year after year. In this way, seemingly small improvements have been *continually* embodied in Patterson Screens without any official announcement. In other words, the performance of a Patterson Screen you buy today, is *better* than the performance of the *same* type of screen when first made available.

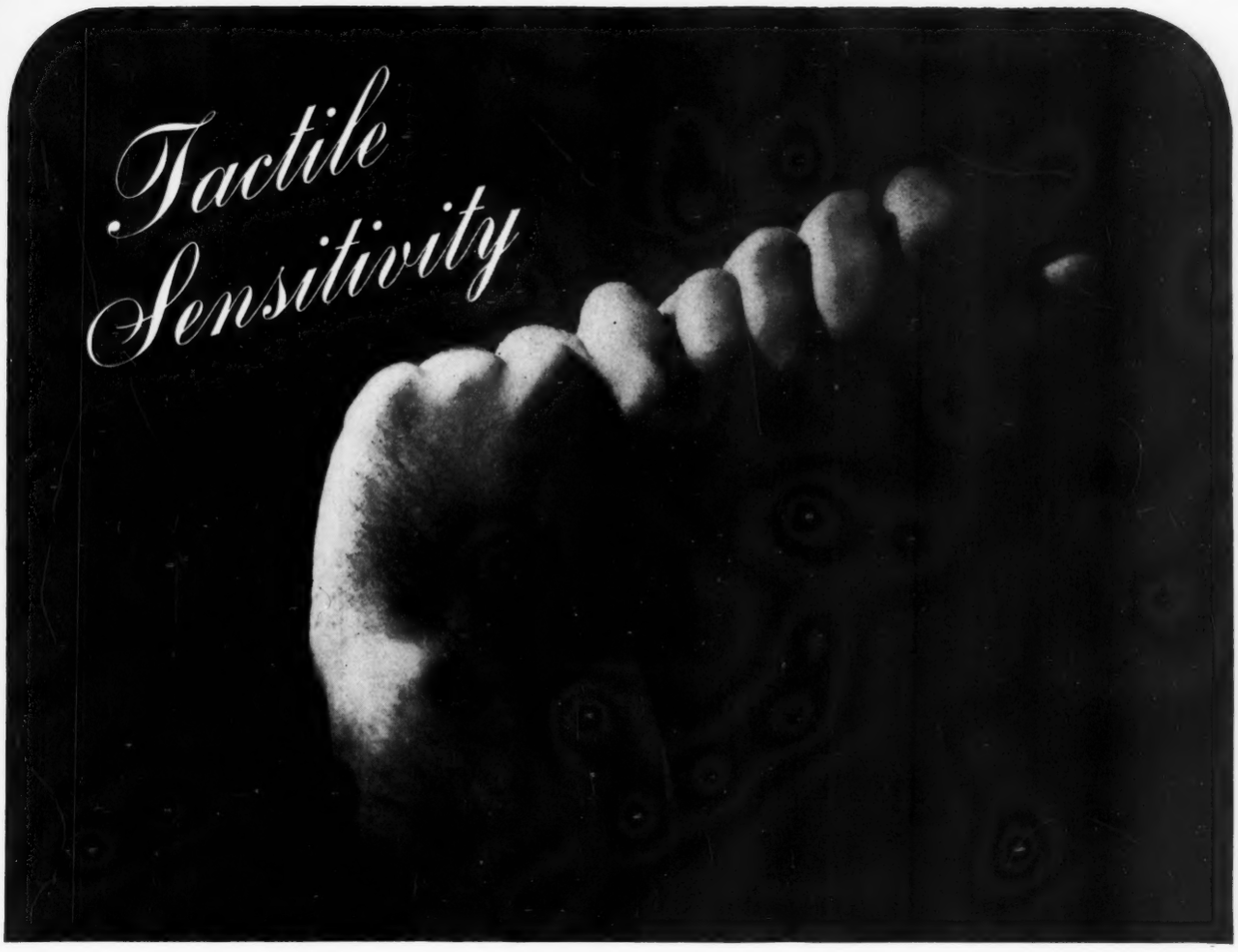
This continuous-research policy of Patterson Screen Company keeps a staff of technical men busy on production and inspection as well as on fundamental research. For example, afterglow is now being studied with the aid of the newly developed Phosphoroscope shown above. Special instruments are utilized to determine the purity of base chemicals. Special care must be taken to eliminate every screen that does not match the standard.

As a result, the exceptionally high quality and uniformity of Patterson Screens is unquestioned. There has been a steady improvement in their wear-resisting properties. Other more evident developments have been greater speed, finer detail and a combination of both.

The worth of this Patterson Research policy is self-apparent, for it has brought to the medical profession the highest possible screen quality and resultant improvements in X-Ray diagnosis.

THE PATTERSON SCREEN COMPANY
TOWANDA, PA., U. S. A.

Patterson • WORLD'S STANDARD FOR HIGHEST SCREEN QUALITY



The professional golfer measures his shot, and with one deft stroke, he's up at the pin. Essential to the successful player are timing, control, and his fingers' sensitive response to the "feel" of the club. To the surgeon, tactile sensitivity is vital too, because it is frequently his only guide. "SR" STANDARD gloves are so amazingly thin, they allow him the undulled sense of touch, the complete finger freedom he once thought possible only if his hands were bare. Yet this gossamer sheerness is startling in its strength and life. These gloves that you choose for *quality* are the gloves that give you *greatest economy*. "SR" STANDARD gloves are famous for staying live and resilient after more than the average number of sterilizations.

Your supply house can furnish these "SR" STANDARD gloves in three types: BROWN LATEX, WHITE LATEX, and BROWN MILLED with banded wrist . . . all easily identified by the "SR" seal.

THE SEAMLESS RUBBER COMPANY, NEW HAVEN, CONN.

Fine Rubber Goods Since 1877

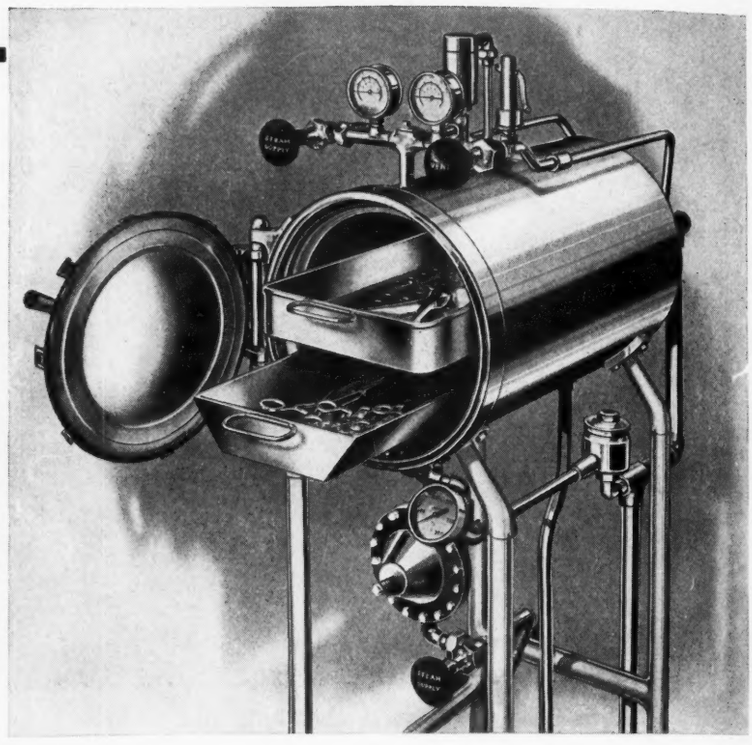
SR

Reg. U. S. Pat. Off

Seamless Standard *Surgeons' Gloves*

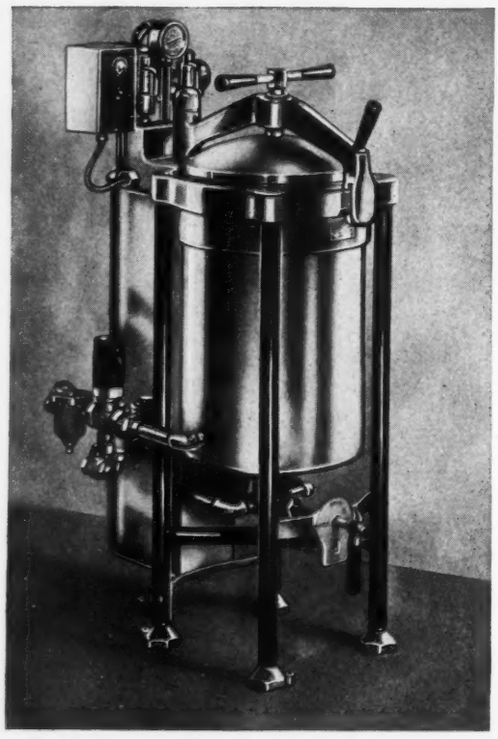
TRY "SR" SURGICAL DRESSINGS — *YOU CAN'T BUY BETTER QUALITY!*

Eliminate the Weak Link *in Surgical Technique . . .*



CASTLE INSTRUMENT WASHER-STERILIZER (below) combines two functions in one unit. In a single 15 minute operation, with adequate steam pressure, instruments are cleaned, sterilized and dried — ready for re-use. Superheated water at 270°F kills all spores.

Convection currents *wash* instruments free from blood, grease and pus. Completely eliminates hand scrubbing and does a better job. Compare this with substitute methods which sterilize instruments without completely washing, making it necessary to wipe off residual matter and re-sterilize.



CASTLE HI-SPEED EMERGENCY INSTRUMENT STERILIZER. (above) For the emergency during an operation—such as dropped instruments or unforeseen change in technique. A sterile instrument back in the Surgeon's hand in 5 minutes. Also for routine sterilization before the morning set-up. Sterilizes at 270°—destroys spore-bearing bacteria and saves time.

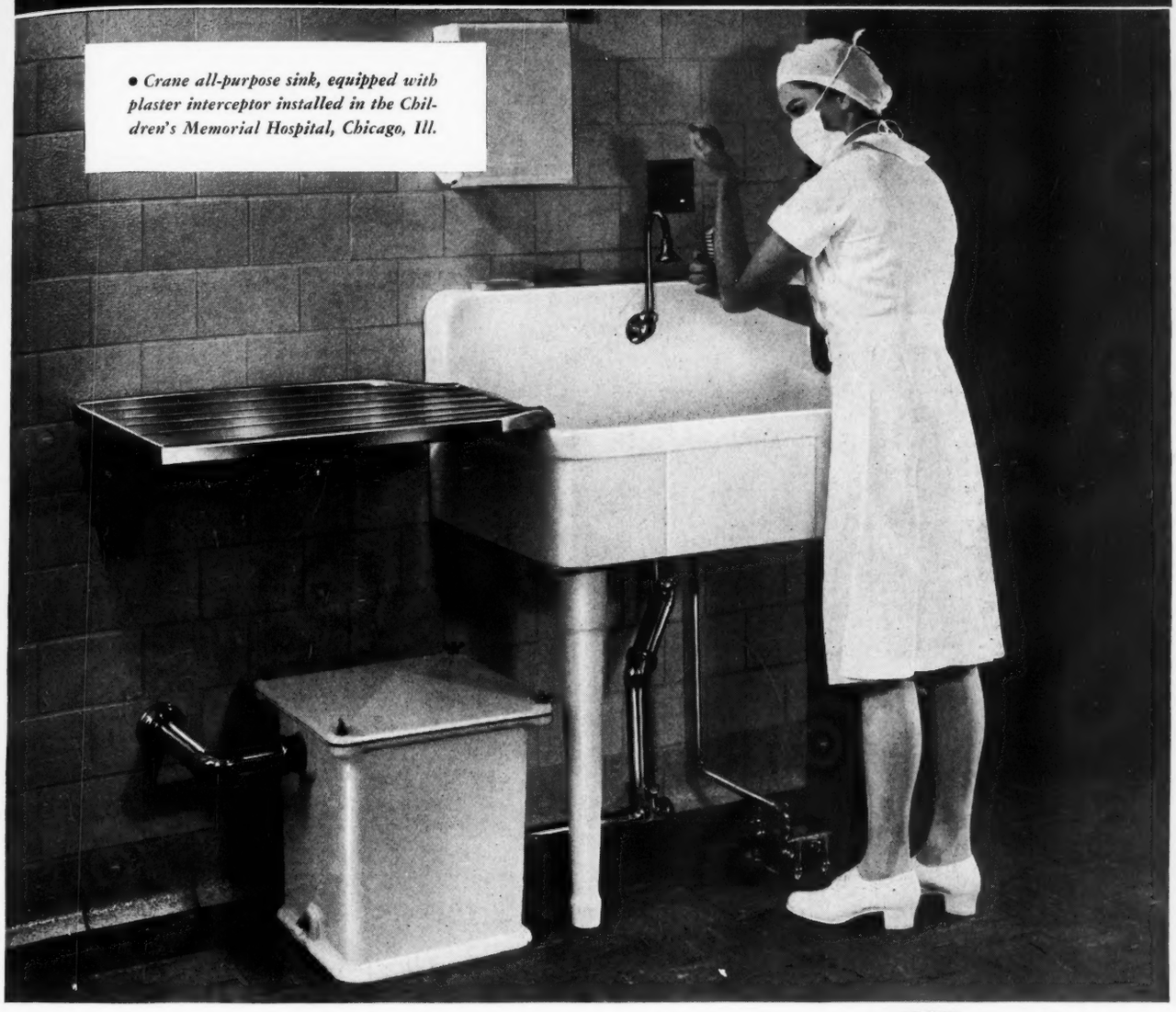
A thousand and one uses include sterilizing test tubes, flasks, small packs, petri dishes, etc.

You will find it to your advantage to consult with our sterilizing engineers.

WILMOT CASTLE COMPANY
1175 UNIVERSITY AVENUE ROCHESTER, N. Y.

CASTLE STERILIZERS
— FOR 55 YEARS —

Crane . . . *The Plumbing Hospitals Prefer*



• Crane all-purpose sink, equipped with plaster interceptor installed in the Children's Memorial Hospital, Chicago, Ill.

THE GLISTEN THAT MEANS *Safety*

THE glisten on this Crane all-purpose sink will *stay on*—for this sink is made of an entirely new, all-ceramic material, Crane *Duraclay.* Its hard and brilliant glass-like surface, so easy to clean, helps assure aseptic safety. And Duraclay—impervious to stains from medicines and ordinary acids—resistant to thermal shock—means safety for the hospital budget, too!

Crane leadership in the hospital plumbing field is founded on years of *knowing* hospital conditions and hospital needs. That is why the complete Crane line of hospital plumbing equipment offers definite aid in increasing hospital convenience and cutting hospital upkeep costs. Your Crane Hospital Catalog is a sure guide to correctness of choice in hospital plumbing fixtures. Use it—and ask about the Crane Budget Plan for hospital modernization.

CRANE

CRANE CO., GENERAL OFFICES: 836 S. MICHIGAN AVENUE, CHICAGO

VALVES • FITTINGS • PIPE • PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

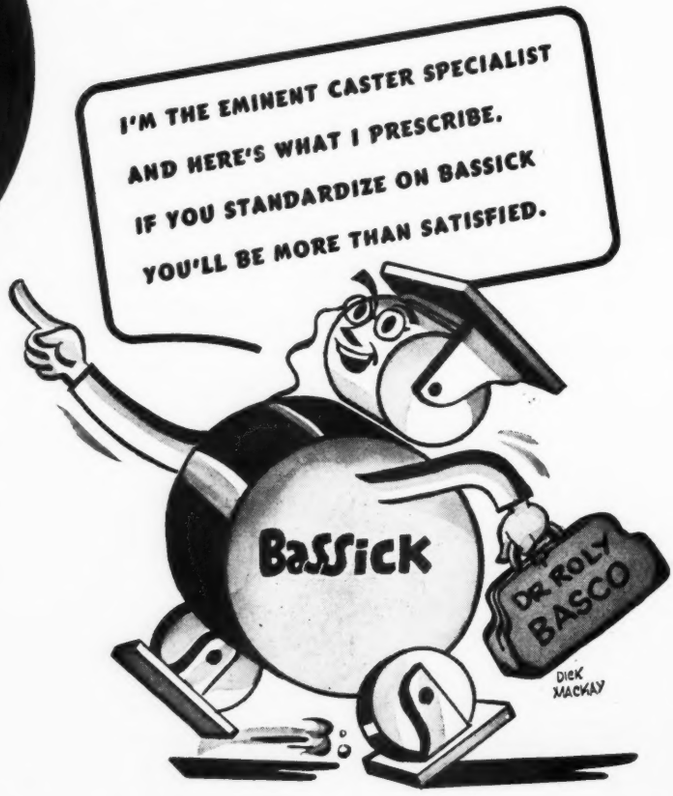
Bassick

INSTITUTIONAL CASTERS

FLOOR PROTECTION EQUIPMENT

There are sizes and types of Bassick casters, glides, Nomar rests, furniture cups, etc., for all institutional furniture and equipment.

Consider the advantage in looking to the largest caster manufacturer in the world as a source of supply for an absolute guarantee of satisfaction, assurance of quality and dependability.



Specify Bassick

DIAMOND ARROW

Full Floating, Ball-Bearing

Hospital Casters

for

Economy

Easy Action

Quietness • Floor Protection

BASSICK REPRESENTATIVES AND DISTRIBUTORS ARE AT YOUR SERVICE

THE BASSICK COMPANY • Bridgeport, Connecticut

Division of the Stewart-Warner Corp., Chicago, Ill.

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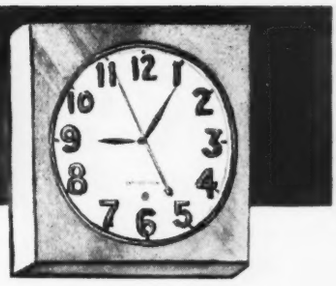


HAVE YOU NOTICED

how early we get our patients' beds changed since the hospital installed a laundry?

Hospitals that have installed AMERICAN 4-MACHINE LAUNDRIES find they always have an adequate supply of freshly laundered linens. That's a big help to the nurses in getting patients' beds changed early each day . . . . leaves the nursing staff free for other duties.

AMERICAN 4-MACHINE LAUNDRY users find they can operate with a smaller linen inventory, too, and assure longest possible service life from their linens. Even more important, laundering costs are kept to the absolute minimum, for equipment investment is surprisingly low and, in many cases, only part time of one operator is required.

Another advantage appreciated by users of the AMERICAN 4-MACHINE LAUNDRY is its compactness . . . for it occupies no more space than the average private patient's room. Yet this inexpensive laundering unit produces thoroughly washed, sterile-clean linens and quickly returns them to service, softly fluffed, or beautifully ironed.

Perhaps an AMERICAN 4-MACHINE LAUNDRY is the answer to your soiled linen problem. Our Laundry Advisory Service, offered absolutely without cost or obligation, will either verify or disprove the practicability of an AMERICAN 4-MACHINE LAUNDRY in your particular case. We invite you to write . . . *today*.

SEND TODAY FOR THIS FULLY ILLUSTRATED 12-PAGE CATALOG ON THE AMERICAN 4-MACHINE LAUNDRY

The AMERICAN LAUNDRY MACHINERY COMPANY

CINCINNATI, OHIO

ASK FOR AN AMERICAN LAUNDRY ADVISER

QUALITY-

Dependability--
Modernity-
Facility-

Attractive and Safe Baby Identification

DEKNATEL NAME-ON BEADS

Necklaces or *Bracelets* bearing the mother's surnames are formed with these beads and SEALED-ON the babies at birth. Irremovable until cut off. The beads are fusible enamel, (not metal), resembling jewelry . . . and are specially compounded for hospital use.

Sample Sent On Request.

DEKNATEL SURGICAL SILK

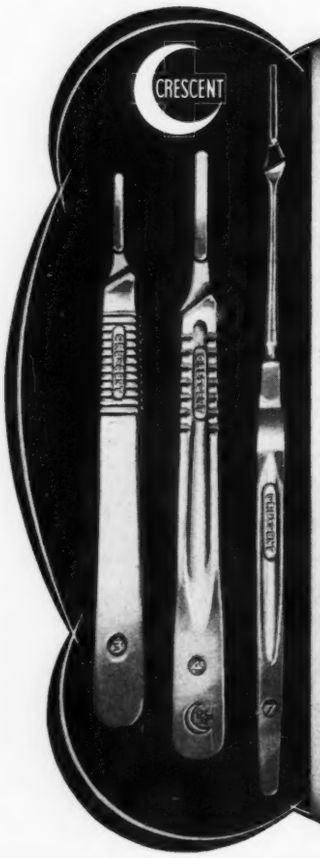
"The Original Moisture and Serum Proof Silk Suture"

Possesses added tensile strength . . . a non-culture medium. Contains no fats or ingredients that will oxidize in the flesh. Resistant to the action of organisms and toxins. Easily manipulated. Widely used as both co-aptation and buried sutures.

Write for Sample.

MADE IN USA

DEKNATEL
QUEENS VILLAGE L. I., NEW YORK



THE HOSPITAL BUYER
can
SERVE TWO MASTERS!

IN surgical blades, the insistent requirements of the most exacting surgeon need not conflict with budget limitations.

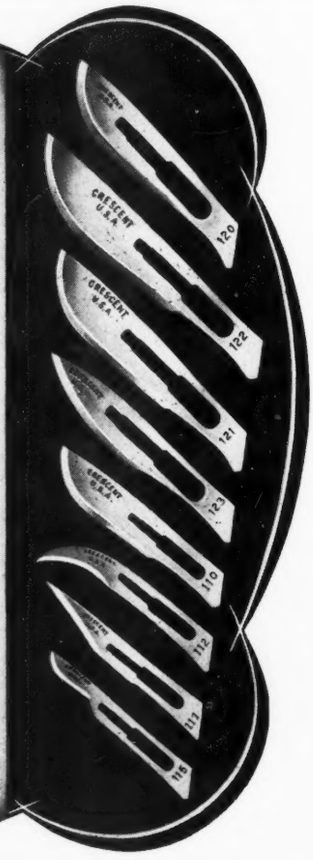
Crescent blades are sharper, more rigid, and better balanced—by virtue of their longer beveled cutting edge on a heavier body, in which one-third more steel is evenly distributed without thinning down from the back.

Crescent blades are more economical—depending on the quantity ordered, they cost up to 30 per cent less.

Your surgical staff and your board of management will both join in approving the specification of Crescent blades, which readily fit all standard handles. Call your surgical dealer . . . or write to

CRESCENT SURGICAL SALES CO., Inc., New York

CRESCENT
SURGICAL BLADES



READY FOR YOU NOW!

A NEW, ENLARGED AND COMPLETELY REVISED

"PYREX" LABORATORY GLASSWARE CATALOG

PRESENTING 358 NEW ITEMS
AND TWO NEW LINES

VYCOR BRAND LABORATORY WARE

PYREX BRAND FRITTED WARE

•This new 160-page Catalog is the most comprehensive listing of laboratory glassware we have yet published. It lists approximately 2700 items of which 358 are new. Included is a complete listing of the items available in the new PYREX brand Fritted Ware, as well as the VYCOR brand Ware fabricated from the new 96% silica glass No. 790.

Prices have been reduced on a number of items. Consumer quantity discounts apply to practically all items when ordered in full original packages, except for a few items which are packed one piece per package. Further economies can be realized if ware is purchased in assortments of 20, 50, or 100 original packages. All items listed are available through your regular laboratory supply dealer.

CORNING GLASS WORKS • CORNING, N. Y.

MAIL THIS COUPON NOW!

Please forward to me a copy of the new "PYREX" Laboratory Glassware Catalog, No. LP-21.

*Name*_____ *Position*_____

*Company or Institution*_____

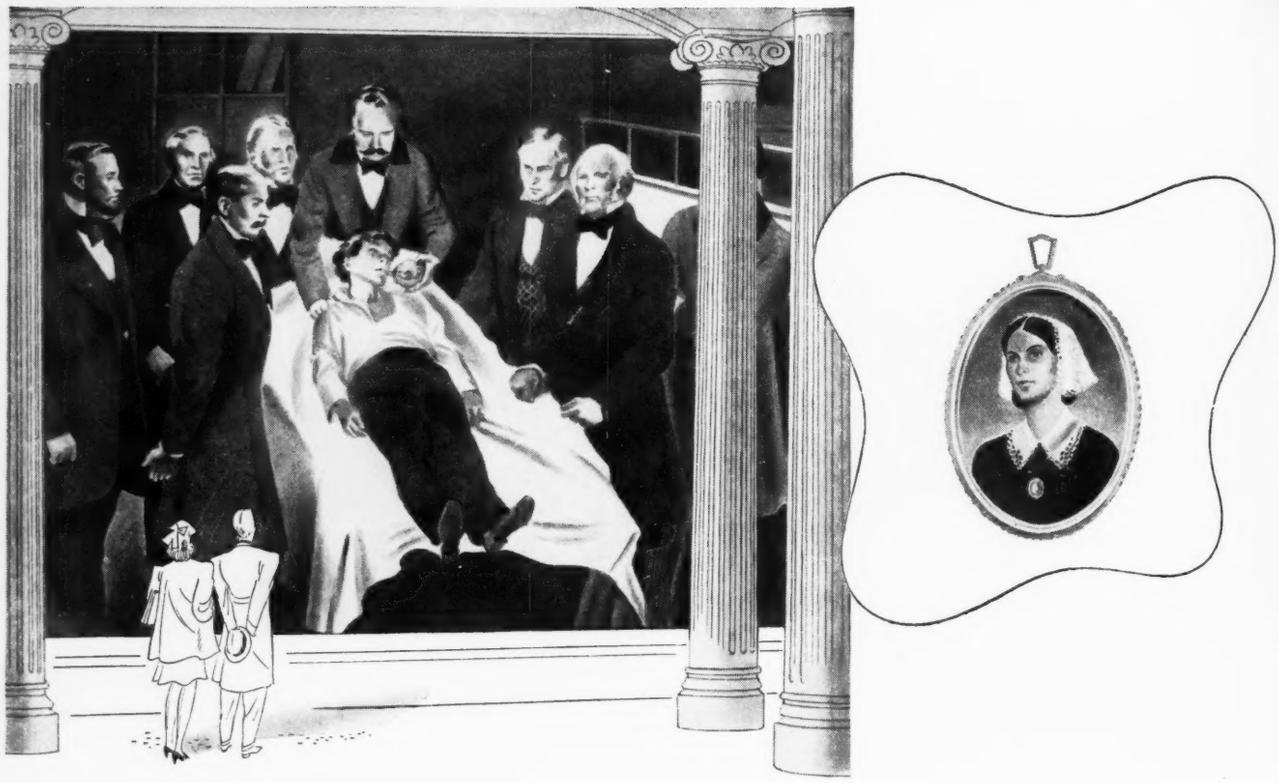
*Address*_____

*City*_____ *State*_____

Please place my name on your regular mailing list ☐

CORNING *means* Research in Glass

Pyrex Laboratory Ware
BRAND



Mural and Miniature BOTH ARE ART

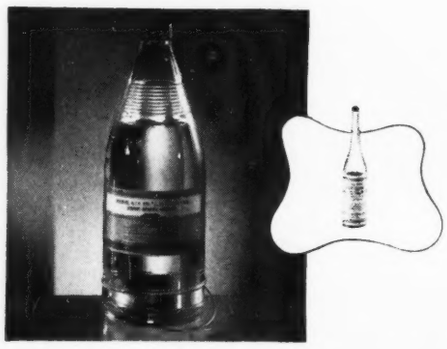
No one can say that a mural is inferior to a miniature, simply because it "covers more ground." The quality of each depends entirely on the ability of the artist.

Similarly, there is no reason to assume that intravenous solutions, manufactured in bulk, must be inferior to the content of an ampoule. Abbott insists that they *shall* be of the same exacting standard—a standard that represents rigid manufacturing and laboratory control from raw material to the finished product—a standard dictated by Abbott's long years of experience in the exacting field of ampoule manufacture.

All solutions are made with freshly distilled water, chemically tested for purity. Further control requires several bacterial counts of the crude dextrose, of the water before use and immediately after solution is made, and again when the containers are filled. After autoclaving, each lot is inspected for foreign particles and tested for chemical impurities and pyrogenic substance. If one sample fails to pass, the entire lot is rejected. It is thus that Abbott safeguards your patients from the possibility of dangerous reaction. ABBOTT LABORATORIES, North Chicago, Illinois.

Abbott

INTRAVENOUS SOLUTIONS



First Aids ON THE ROAD TO RECOVERY

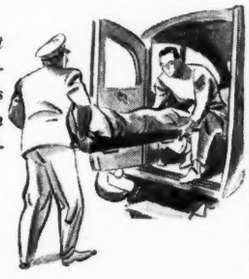
Wherever comfort is the primary concern, AIRFOAM has first call with hospitals and other institutions

THE amazing popularity of **Airfoam** mattresses, ambulance and operating pads, ring seats, and knee rests can be accounted for in just one word, "comfort." **Airfoam** is composed of millions of tiny lungs through which it inhales and exhales. This breathing action permits it to conform to every posture, to every turn and twist of the body. On this unbelievably soft and pliable material the patient actually floats on air.

Airfoam's therapeutic value is everywhere recognized in cases where absolute rest or firm, buoyant support is needed. But beyond that, it has many other advantages. **Airfoam** is odorless, dustless and inhibitive to vermin and bacteria. It can be easily sterilized. And it never sags or loses its life—it lasts for years and years.

Airfoam is a pure cellular latex product made only by Goodyear. If your supply house does not handle, write Goodyear, Akron, Ohio.

Airfoam—T. M. The Goodyear Tire & Rubber Company



Hospitals report AIRFOAM ambulance pads lessen pain in moving the badly injured

THE NEW NAME FOR COMFORT

Airfoam

MADE ONLY BY

GOODYEAR

TICK TICK

IT'S THE FIRST 60 SECONDS THAT COUNT

For the price of a local telephone call...
you can **guard each operation** *against darkness*

The nickel you drop in the coin box is enough to pay for Exide Emergency Lighting protection during the course of each operation in your hospital. An average of less than five cents per operation covers the original cost of an Exide Unit and its operating cost as well!

The utility companies take every precaution, but cannot control the effects of storms, floods, fires, or street accidents. Exide Emergency Lighting operates *instantaneously* and *automatically* upon any interruption of the normal electric current supply. The only attention these units require is the addition of water a few times a year.

An Exide System for smaller hospitals protects both operating lights and general illumination in two operating rooms . . . and also safeguards the accident dispensary, sterilizing, delivery and medicine rooms, plus any other room desired. There are larger Exide Systems for large hospitals. Why not write for free bulletin?

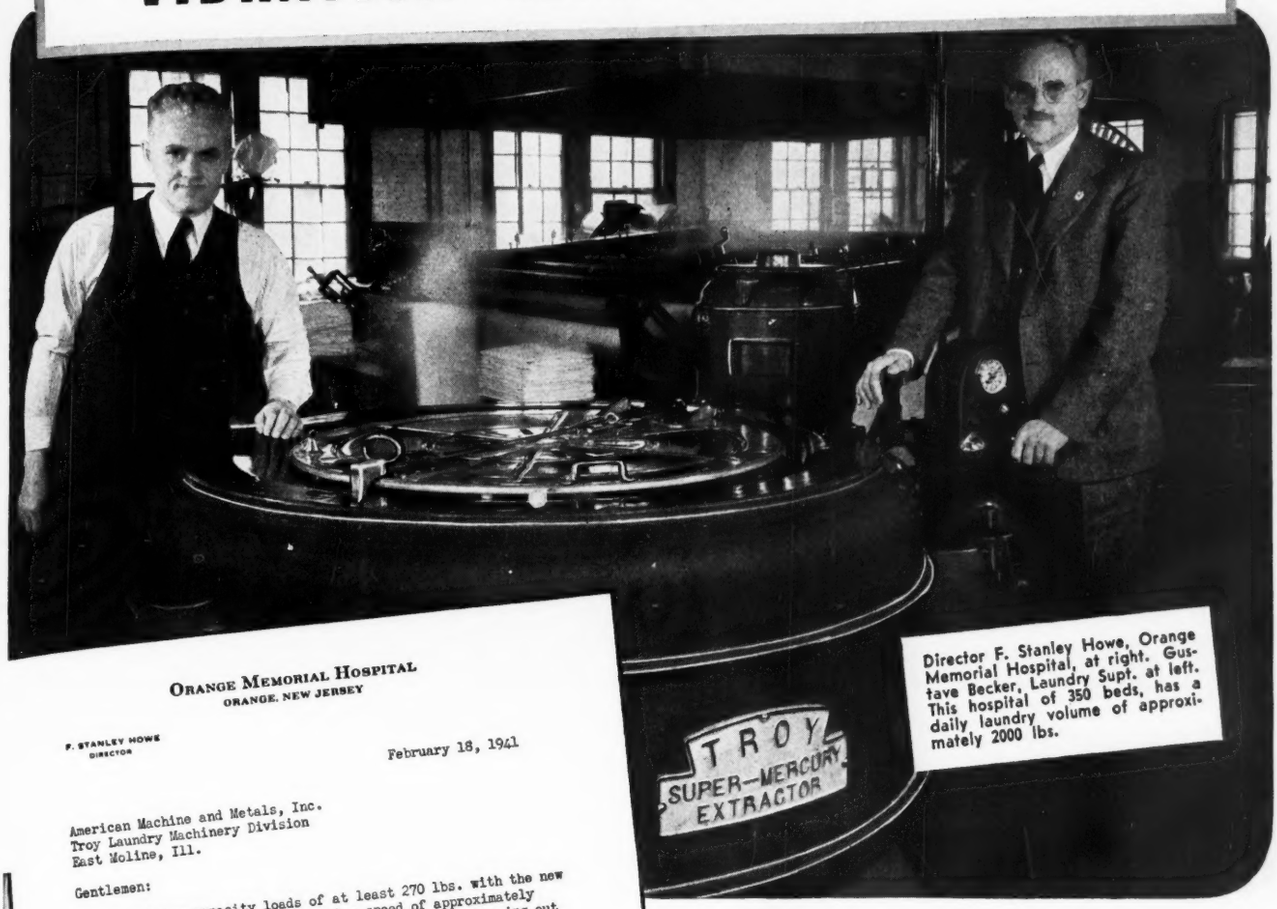
Exide
Keepalite

EMERGENCY LIGHTING UNITS

THE ELECTRIC STORAGE BATTERY COMPANY, Philadelphia
The World's Largest Manufacturers of Storage Batteries for Every Purpose
Exide Batteries of Canada, Limited, Toronto

LAUNDRY EXTRACTION TIME REDUCED 60% — VIBRATION ELIMINATED

IN ORANGE MEMORIAL HOSPITAL, ORANGE, N. J.



Director F. Stanley Howe, Orange Memorial Hospital, at right. Gustave Becker, Laundry Supt. at left. This hospital of 350 beds, has a daily laundry volume of approximately 2000 lbs.

ORANGE MEMORIAL HOSPITAL
ORANGE, NEW JERSEY

F. STANLEY HOWE
DIRECTOR

February 18, 1941

American Machine and Metals, Inc.
Troy Laundry Machinery Division
East Moline, Ill.

Gentlemen:

We are getting capacity loads of at least 270 lbs. with the new 48-inch Super Mercury Extractor at a speed of approximately 1000 revolutions a minute, which means that we are turning out these loads in an average of only eight minutes, compared to our former running cycle of about twenty minutes.

As our Laundry is located on the second floor of our steam plant, the location is far from ideal so far as vibration is concerned. In spite of this, however, and with two other vibrating extractors operating close by, your Super Mercury gives us consistent maximum efficiency without any hint of vibration.

As a practical illustration of this fact, I have actually seen a coin balanced on edge on the rim of this machine while running at full speed and fully loaded. So free from vibration was the apparatus that the coin balanced without support. We shall be glad to demonstrate this for the satisfaction of any who may be inclined to doubt this statement.

Very truly yours,

Stanley Howe

Director

FSH:HM

MEMBER

New TROY 1000 R.P.M. SUPER MERCURY

Reduction of extraction time as much as 60% with the new 1000 R.P.M. SUPER MERCURY 48" Extractor has been proved by actual tests. This remarkable reduction of extraction time is accomplished safely because the new 1000 R.P.M. SUPER MERCURY incorporates TROY'S famous self-balancing principle. The basket is free to compensate for an unbalanced load. Vibration is eliminated. Similar time savings are possible in your laundry room. Write for details. Use the convenient coupon below!

MAIL COUPON TODAY!

TROY

LAUNDRY MACHINERY DIVISION
American Machine and Metals, Inc.

TROY LAUNDRY MACHINERY DIVISION
606 Troy St., East Moline, Ill.

Yes Send me details on the New TROY SUPER MERCURY EXTRACTOR.

Name_____

Institution Name_____

Address_____

City_____ State_____

. . . . *this* **HORNER BLANKET**

is a big favorite with hospitals because it is beautiful, warm, light weight and INEXPENSIVE. Write Dept. M6 for samples and details.

Look for the Horner Label—It is your guarantee of satisfaction.

HORNER WOOLEN MILLS COMPANY
EATON RAPIDS MICHIGAN

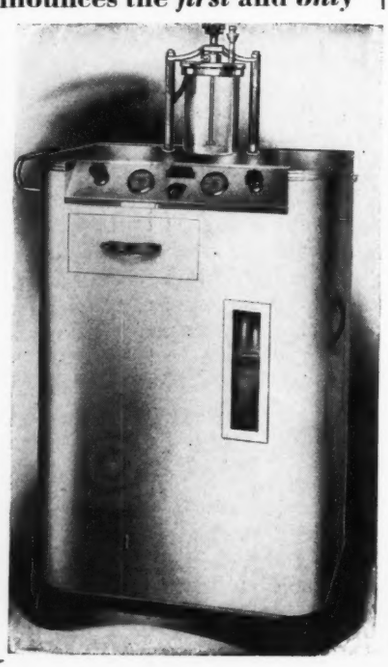
An Important New Line of Hospital Pumps

EXPLOSION PROOF

Even in Ethyl-Ether Atmosphere

★ ★ ★ ★ ★ ★ ★ ★

Gomco proudly announces the *first* and *only* Suction and Ether Pump units with electric equipment fully approved by the Underwriters' Laboratories for use in Ethyl-Ether atmosphere
(Class I Group C)



These newsworthy pump units incorporate many other important exclusive Gomco features, assuring long superlative service. Write for detailed literature; learn how these units will fit *your* requirements.

GOMCO
SURGICAL MFG. CORPORATION
87 Ellicott Street
BUFFALO, NEW YORK

***Positive* IDENTIFICATION**

Your fingerprint is a positive identification. But to mark your possessions against loss or misuse there is a better method — Cash's Names attached to every article you want identified.

See that uniforms and other clothing carry the owner's name. Have towels, sheets, blankets, etc. marked for each ward. And be sure to use Cash's ***Woven*** Names. They're permanent, economical, easy to attach with thread or Cash's NO-SO Cement (25c a tube.)

Personal Name Prices	12 doz. $3.00	9 doz. $2.50
	6 doz. 2.00	3 doz. 1.50

A larger size, ***Woven*** on half-inch tape, is widely used for attaching to sleeves or caps of uniforms.

SPECIAL! For those who desire woven name quality at the lowest possible price we offer Cash's ***JACQUARD*** Woven Names in 3 styles. Ask about them.

Write and let us figure on your needs, whether institutional or personal

CASH'S
211 Chestnut St., So. Norwalk, Conn., or 6208 So. Gramercy Pl., Los Angeles, California.

THE INSIDE STORY OF 4 SMALL ORGANISMS

In saturated steam (Fig. A) organisms are destroyed rapidly. In mixtures of steam and air (Fig. B) thermal death times may be three or four times as great as in saturated steam. In saturated steam, Sterilometer reacts rapidly but with sufficient margin of safety. In mixtures of air and steam, the action of Sterilometer is retarded in approximately the same proportion as they increase thermal death times.

Sterilometer tells the story inside the packs. It does not react until sterilizing conditions which will destroy all pathogenic organisms have been created *inside* the packs.

A Sterilometer in each pack is your safeguard. If you have not used Sterilometer in your surgery, write us at once for samples and proof.

$2.00 PER 100

STERILOMETER LABORATORIES, Inc.
318 N. Central Ave., Glendale, Calif.

Incorporating exclusive new features never before used, the Standard Tilting Fluoroscopic Table provides the greatest possible efficiency, convenience and patient comfort. In addition, it possesses a beautiful symmetry of design.

An outstanding feature is the complete elimination of the transverse movement of the upright screen supporting arm, although the fluoroscopic tube, fluoroscopic screen and shutter controls have a cross travel of 9 inches. The "pantograph" screen assembly which permits the radiographic tube stand to be placed very near the table—and yet out of the way, is clearly shown above. Considerably less floor space is required for installation.

Electrical Shutter control provides automatic compensation for limiting fluorescent area to full screen area—an advantage not found in conventional tables. Bi-Plane fluoroscopy is available by addition of a vertical screen. A hinged, recessed step is provided for mounting or dismounting. A curved panel at the end of the table moves back allowing ample knee room.

This fine Model "F" Table may be had in crank tilt or motor driven models.

Write today for specifications and complete literature on this Standard, Shockproof, Full length Combination Fluoroscopic and Radiographic Table.

STANDARD X-RAY CO.

Pioneers in X-Ray Equipment for over 30 years

General Offices & Factory: 1932-42 N. Burling St., Chicago

Branch Offices and Distributors Throughout the World

WRITE FOR OUR NEW ACCESSORY AND SUPPLY CATALOGUE

The Newer Concepts of Meat in Nutrition

Meat . . .

and the Daily Protein Requirement in Nephritis and Nephrosis

ALTHOUGH Farr and Smadel[1] observed intense renal scarring in nephrotic animals fed an excessive (40 per cent) protein ration, McCann[2] cautions against the assumption that a normal protein intake will prove harmful under the same circumstances.

The protein intake in nephritis and nephrosis must be considered not only in the light of alleged kidney damage produced by end products of protein metabolism, but also and chiefly as to its need for tissue maintenance and for replacement of the proteins lost in the urine.

Inadequate protein intake will result in a low plasma content which according to Van Slyke[3] has unfavorable prognostic significance.

Meat, a reliable source of complete proteins, as a rule is more than acceptable to the appetite of the nephrotic or nephritic patient, even when offered several times every day. When proteinuria is pronounced, Mosenthal[4] estimates the average protein need as from 100 to 125 Gm. daily, an amount supplied by 500 to 625 Gm. of meat. The inclusion of liberal amounts of protein-rich foods in the diet of the nephritic or nephrotic will prevent the plasma-protein deficit which so unfavorably alters the outlook in these diseases.

1. Farr, C. E., and Smadel, J. E., cited in Diet and Nephritis, Editorial, J.A.M.A. *109*:1202, 1937.
2. McCann, W. S.: The Many-Sided Question of Protein in Nephritis, Ann. Int. Med. *5*:579, 1931.
3. Van Slyke, D. D., et al.: Observations on the Courses of Different Types of Bright's Disease and on Resultant Changes in Renal Anatomy, Medicine *9*:257, 1930.
4. Mosenthal, H. O.: Chronic Diffuse Glomerular Nephritis, New York State J. Med. *37*:268, 1937.

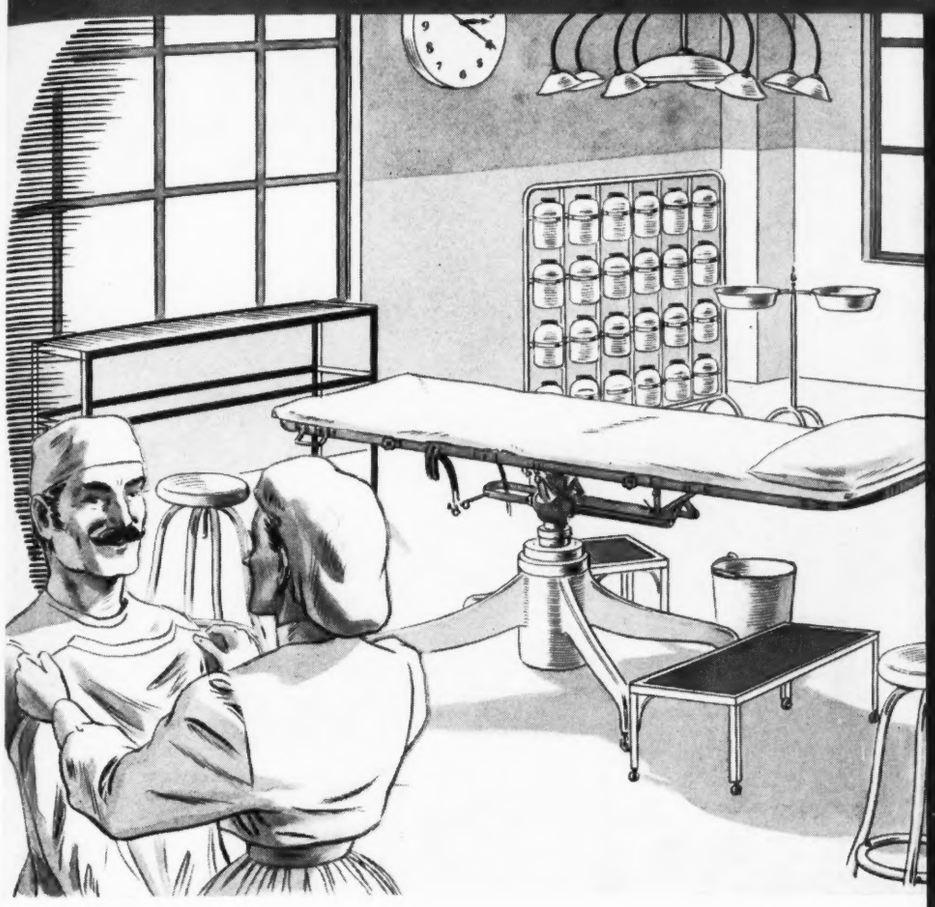
The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

American Meat Institute

CHICAGO

SIMMONS STAINLESS STEEL



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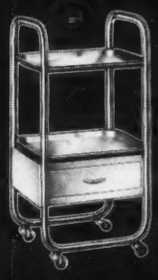
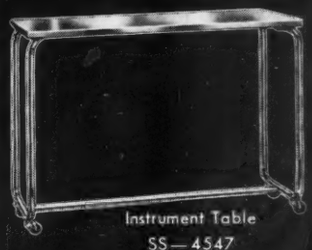


Anesthetist's Table
SS-3944

Instrument Stand
SS-3941

Double Irrigation Stand
SS-3940



Instrument Table
SS—4547

Double Solution Stand
SS—3946

Kick Bucket
SS-3100

THEY DID A GOOD JOB—

Considering the Equipment They Had to Work With . . .

MEDICINE and surgery are advancing rapidly. Nowhere is it more apparent than in operating and examining room equipment. A direct comparison between equipment of years ago and modern Simmons Stainless Steel Equipment is a graphic illustration of hospital progress.

Simmons Stainless Steel Equipment is modern in lines, with new-day efficiency. It combines all the advantages of stainless steel with Simmons design and construction, long noted for durable hospital furniture. Every piece is completely welded throughout, assuring maximum rigidity, longer life and ability to withstand abuse. There are no bolts or screws to loosen. Rust-and stain-resistant, it assures absolute sanitation with a minimum of effort. There are no troublesome seams or crevices. Sterilization has no detrimental effects—and it has no coating to chip, crack, peel or wear away. Send for full facts on this forward step in operating and examining room equipment. No obligation.

Simmons Steel Furniture for Hospitals and Nurses' Homes

Simmons Steel Hospital Furniture has been famed for 25 years—assuring beauty, durability, utility value and economy. It is now in use in leading hospitals and nurses' homes in all sections of the country. Write for full details today.

Display Rooms: New York, Chicago, Atlanta, San Francisco.

SIMMONS COMPANY
STAINLESS STEEL DIVISION
☆
383 MADISON AVE. • NEW YORK, N. Y.

"RESERVE STRENGTH"

That's what brings

PEQUOT

SHEETS and PILLOW CASES

through many a hospital hazard

SOMETIMES all medical experience says "impossible," and still the patient lives . . . thanks to an extra reserve of strength. Often experienced buyers are amazed at the merciless punishment a Pequot Sheet can take . . . and survive.

Let's say that Pequots, too, have a kind of "reserve strength." That covers many fine points in conscientious sheet-making. Such as live, strong, long, selected cotton—and an old-time New England skill in weaving. This produces a magnificent texture—firm, strong, smooth and uniform.

This *extra* care means *extra* vitality for the *extra* hazards your sheets have to endure.

We urge you to try Pequots. Only your own experience can show you the almost-miracle of Pequot wear.

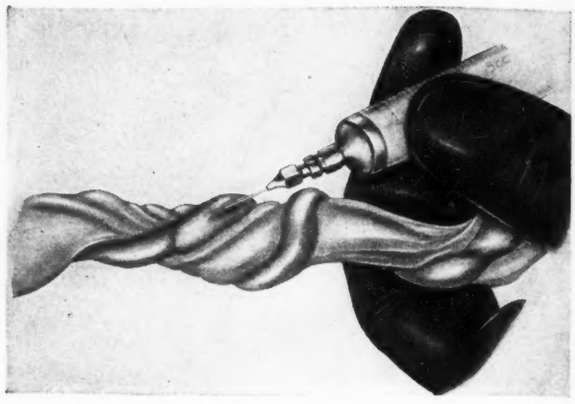
PEQUOT MILLS

PEQUOT SHEETS PILLOW CASES

GENERAL SALES OFFICES: 21 EAST 26th ST., N. Y. C.
BOSTON • PHILADELPHIA • CHICAGO • SAN FRANCISCO

LOBELIN

-Bischoff



Injection into the umbilical vein usually initiates normal respiration in a few seconds

FOR

Quick Action

IN

NEONATAL ASPHYXIA

ERNST **Bischoff** CO., INC.
IVORYTON, CONNECTICUT

FAMOUS HOSPITALS

BELLEVUE HOSPITAL—*New York*

From a single room in a building where New York's City Hall now stands, to a spacious, well-equipped hospital on East River. From a six bed ward to a capacity for more than 2,500 patients. First hospital to introduce the modern training school for nurses. Provided first ambulance service in the city for other than contagious disease cases. Bellevue has written its record indelibly into the history of the world's greatest hospitals. Illustration shows Bellevue as it looked in 1848.

And this Today is Our Most Prized Possession

Fame may come overnight to some. But, in hospitals and laboratories, laurel wreaths are not lightly won; fame seldom comes with only a single achievement.

It was when many of today's outstanding hospitals were in their early development that Miller research first won the regard of the men in white. The first surgeons gloves without seams . . . the neck-contoured throat collar . . . pure gum surgical tubing in 50-foot continuous lengths . . . the new anode-latex Heatiator heat therapy unit . . . these are only a few of the achievements which have built lasting fame for the name of Miller. And this fame today is our most prized possession. Miller Rubber Company, Inc., Akron, O.

Miller Anode Surgeons Gloves, made of pure latex by the patented Anode process, afford greater service life and resistance to repeated sterilizations. Patterned after the natural shape of the hand, they give freedom without binding—protection without impairing touch.

Miller

THE ONE WORD SPECIFICATION

"Diack Controls are better than infected Patients for telling whether your sterilization has been properly done."

A. W. DIACK 5719 WOODWARD AVENUE DETROIT, MICHIGAN

SPECIFY SHELDON for LABORATORY FURNITURE

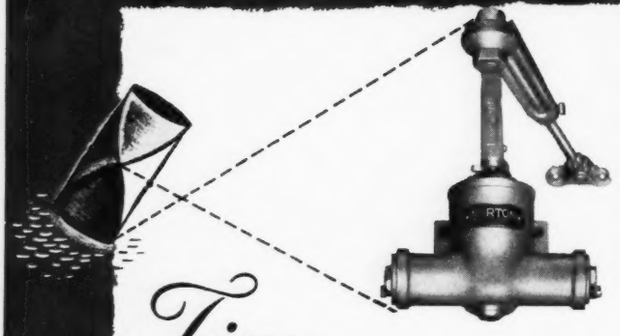
CORRECTIONS are easy on paper HARD IN CONCRETE

It is far easier to erase and correct a tracing than to tear up a concrete floor. Sheldon's Engineering Service is designed to eliminate costly mistakes caused by hasty or improper laboratory planning.

A Sheldon Sales Engineer is near you or your architect to assist in laying out your laboratory facilities. Write today for our catalog of wood and metal laboratory furniture.

E. H. SHELDON & CO.
MUSKEGON 734 NIMS STREET MICHIGAN

NORTON DOOR CLOSER



Time FOR INSPECTION

Regular inspection helps keep door closers operating at peak efficiency. Often, minor repairs or adjustments made in time save dollars later. If new installations and replacements are indicated, select the Norton with positive control and leakproof mineral oil lubrication. Write for the Norton catalog.

NORTON DOOR CLOSER CO.
Division of the Yale & Towne Mfg. Company
2908 N. Western Ave. Chicago, Illinois

. . . is the 100 Series *Finnell* in performance that you can scrub and polish hospital floors at any hour, and in most any place, without disturbing patients. It's built throughout for quiet operation . . . gears and bearings run in an extra-capacity lubricated gear case. And here's another of the distinguishing features of the 100 Series *Finnell*. It's *two sizes in one*. An interchangeable brush ring adjusts the larger sizes for the small spaces. Thus, the one machine can be used in individual rooms as well as in corridors, wards, and other large areas. And note the low offset design . . . permits use around and beneath low-set furnishings and fixtures.

For *free demonstration* on your own floors, consultation, or literature, phone nearest *Finnell* branch, or write Finnell System, Inc., 1406 East Street, Elkhart, Indiana.

FINNELL SYSTEM, INC.
Pioneers and Specialists in FLOOR MAINTENANCE EQUIPMENT

A FENWAL INSTALLATION

will extend the purchasing power of your

STERILE SOLUTION DOLLAR

. . . many times over

THIS FEATURE ALSO SAVES YOU MONEY

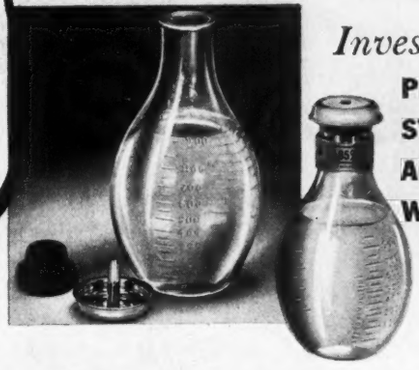
Fenwal Container-dispensers are re-usable

They are highly resistant to mechanical and thermal shock. The stable, annealed surface of the glass resists hydrolysis by the solutions. They provide for storage under perfect vacuum. Their design facilitates rapid and thorough cleansing.

TEL-O-SEAL hermetic closures are re-usable

The rubber bushing is molded of a non-toxic, heat-resistant rubber which retains its resiliency after repeated sterilization. The stopper is made of corrosion-resisting, stainless steel which will withstand the attack of saline solutions. It will not tarnish from an atmosphere of air or steam.

Whether the volume consumption of your hospital is 500 or 20,000 liters annually, a compact and easily operated FENWAL SYSTEM can be adapted to accomodate your needs at surprisingly low cost. The preparation of *safe* parenteral fluids becomes a matter of simplified routine procedure. The greatly reduced per-unit cost of solutions insures adequate parenteral therapy for every patient.



Investigate Fenwal

PREPARATION UNITS
STORAGE UNITS
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WASHING UNITS

We invite your direct inquiry

MACALASTER BICKNELL COMPANY

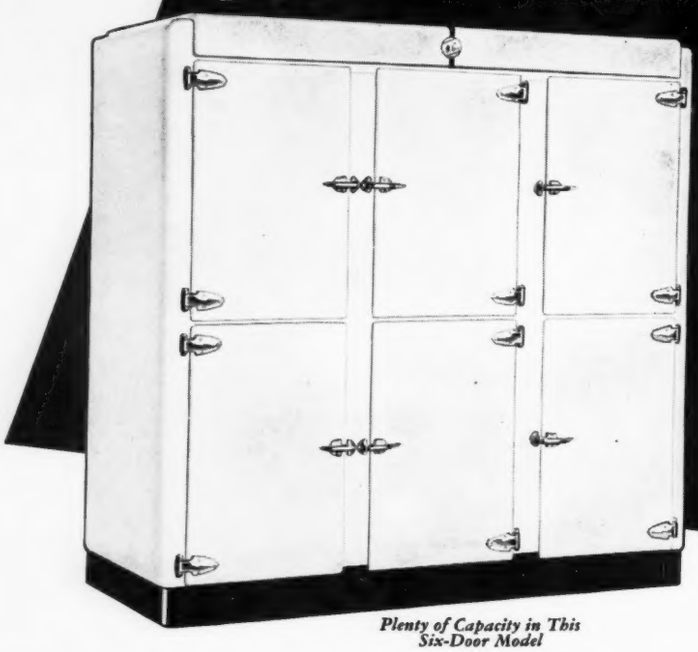
243 Broadway — Cambridge, Massachusetts

Fenwal

THE SOLUTION DESIRED AT THE INSTANT REQUIRED

In Refrigeration...

DEPEND ON McCRAY TO DO A BETTER JOB



Plenty of Capacity in This Six-Door Model

Most Kitchens Need at Least One Cabinet of This Size

Keeping costs lower, so departmental efficiency can rank higher!

In any food department, that's the job of refrigeration—a job that McCray does *better.* You can depend on it, as hundreds of hospitals and institutions already do, and have done for years.

Food costs are lower with McCray because food keeps better in McCray's famous Three-Dimensional Refrigeration (perfectly balanced temperature, humidity, air circulation). There's much less shrinkage from evaporation, spoilage is held to the barest minimum.

Operation and maintenance costs are lower, because McCrays are engineered for extra efficiency, craftsman-made for long, trouble-free service. In a well-run kitchen, there's even a saving in labor. Salads, desserts, and other delicacies can be prepared further ahead of serving time; McCray's perfect protection keeps them fresh and tempting.

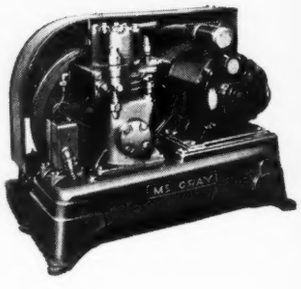
"Depend on McCray," too, because McCray men sell from a *complete* line. They never have to hedge on their recommendations in order to make a sale from an inadequate line.

You want the best possible refrigeration at the lowest per-year cost. Then why not have a talk with a McCray man today? You'll not be obligated in any way.

McCray Refrigerator Co., 166 McCray Court, Kendallville, Indiana. Salesrooms in All Principal Cities. Consult Your Telephone Directory.

McCRAY
TRIPLE-BALANCED
REFRIGERATION

Cabinet, coils, and condensing unit engineered to work together at top efficiency. No under-capacity; no over-capacity. No divided responsibility: McCray stands behind the entire installation.



McCRAY • • BACKED BY 51 YEARS' EXPERIENCE

Mr. Superintendent—

YOU Are Interested in X-ray . . .

YOUR X-RAY DEPARTMENT INVOLVES A SUBSTANTIAL INVESTMENT. BEFORE YOU INVEST— INVESTIGATE THE FACTS

Our business deals with x-ray — and x-ray alone. That Picker-Waite X-Ray Apparatus has been the choice of many leading Roentgenologists and Hospitals for over 40 years is a significant tribute to its superior features.

If you and your board are considering x-ray apparatus as an initial installation or for purposes of replacement, you will surely be interested in the factual information contained in our catalogues. As the oldest and largest manufacturer of x-ray equipment exclusively, we are in a position to serve you effectively.

A representative list of Picker-Waite installations, together with pertinent information on shockproof x-ray diagnostic or therapy equipment will be mailed upon request. Simply check the type of bulletins required in the coupon below.

PICKER X-RAY CORPORATION
300 Fourth Avenue • New York, N. Y.

Gentlemen:

I am interested in shockproof diagnostic x-ray apparatus—shockproof Therapy equipment—x-ray supplies—x-ray accessories.

Name .....

Hospital .....

City ..... State .....

PICKER X-RAY CORPORATION

WAITE MANUFACTURING DIVISION, CLEVELAND, O.

St. John's Hospital, Springfield, Illinois, one of the many modern medical institutions which have selected the G-E Model KX-8-33 to meet their high-power requirements.

BEFORE SELECTING HIGH-POWER X-RAY EQUIPMENT FOR YOUR INSTITUTION · · · · · CHECK THE FACTS!

VALUE-WISE medical men who dig deep into cost and performance records have found that true x-ray economy is more than just "How much does it cost?" The big thing is end results *plus* dependable, economical operation.

To get the full story about the G-E Model KX-8-33 500-milliampere x-ray unit's ability to produce consistently the finest diagnostic results, and its enviable record for low cost operation, call in your local G-E X-Ray representative.

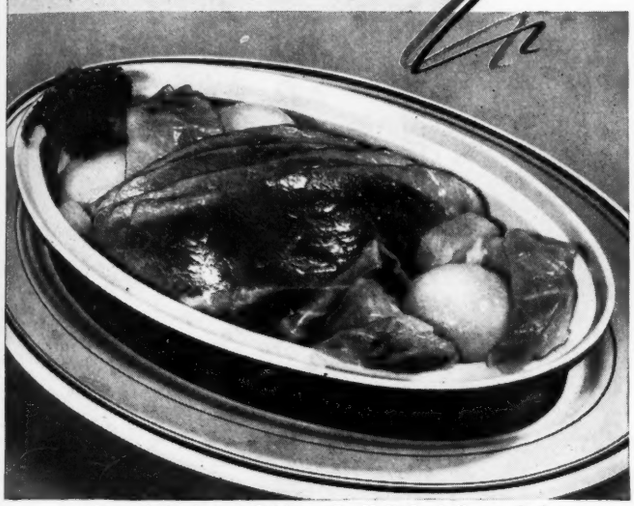
From him you will get performance facts and figures based on the experience of hundreds of satisfied users. From him, too, you will get complete information about the KX-8-33 unit's radiographically-calibrated heavy-duty transformer; its new, unusually easy-to-operate Centralinear Control; and its full flexibility over its wide range of service.

To request your local G-E X-Ray representative to call, at your convenience, or to request further information about the G-E Model KX-8-33, write, today, to Department K56.

GENERAL ELECTRIC X-RAY CORPORATION

2012 JACKSON BLVD. CHICAGO, ILL., U. S. A.

"3 reasons why HALL CHINA IS PREFERRED FOR CASSEROLE COOKING"



Corned Beef And Cabbage In Hall Oval Casserole
An old favorite, individually served, reaches a new high in appetizing appeal . . . its rich, full flavor "sealed-in" by the gleaming, white walls of a Hall casserole.

Sweetbreads In Hall French Shirred Egg Dish
Good to look at and just as good to eat . . . creamed sweetbreads, Virginia style ham, and crisp vegetables topped with a piquant cream sauce . . . in a Hall China baking dish.

1

ASSURES PERFECT BAKING The heavy, fireproof walls of Hall Secret Process China diffuse direct oven heat so that all the contents of the casserole are subjected to an even, steady temperature. Food is thoroughly cooked. Flavor is rich, full, and unscorched. There are no burnt bottoms or edges while the inside is just half-done when Hall China is used.

2

KEEPS FOOD HOT Hall China "seals-in" the heat . . . and the flavor too—for the fine texture of its thick body retards heat loss, and completely prevents staining and absorption. The use of Hall China minimizes complaints about cold servings, "off-taste," and discoloration.

3

ALWAYS LOOKS "NEW" Hall China cannot craze and the color will not fade or wear away . . . for body, glaze, and color are fused together by an exclusive, secret process. Hall China resists chipping because it has a safety-measure of strength where it counts—in rims, lips, and handles. It is easy-to-clean and gleams like new even after long, hard use.

The Hall China Company, East Liverpool, Ohio
World's Largest Manufacturer of Fireproof Cooking China

Quantity recipes illustrated sent on request to our Hospital Division

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HALL
Secret Process
FIREPROOF CHINA

THE QUIET OF HIDDEN FOREST POOLS

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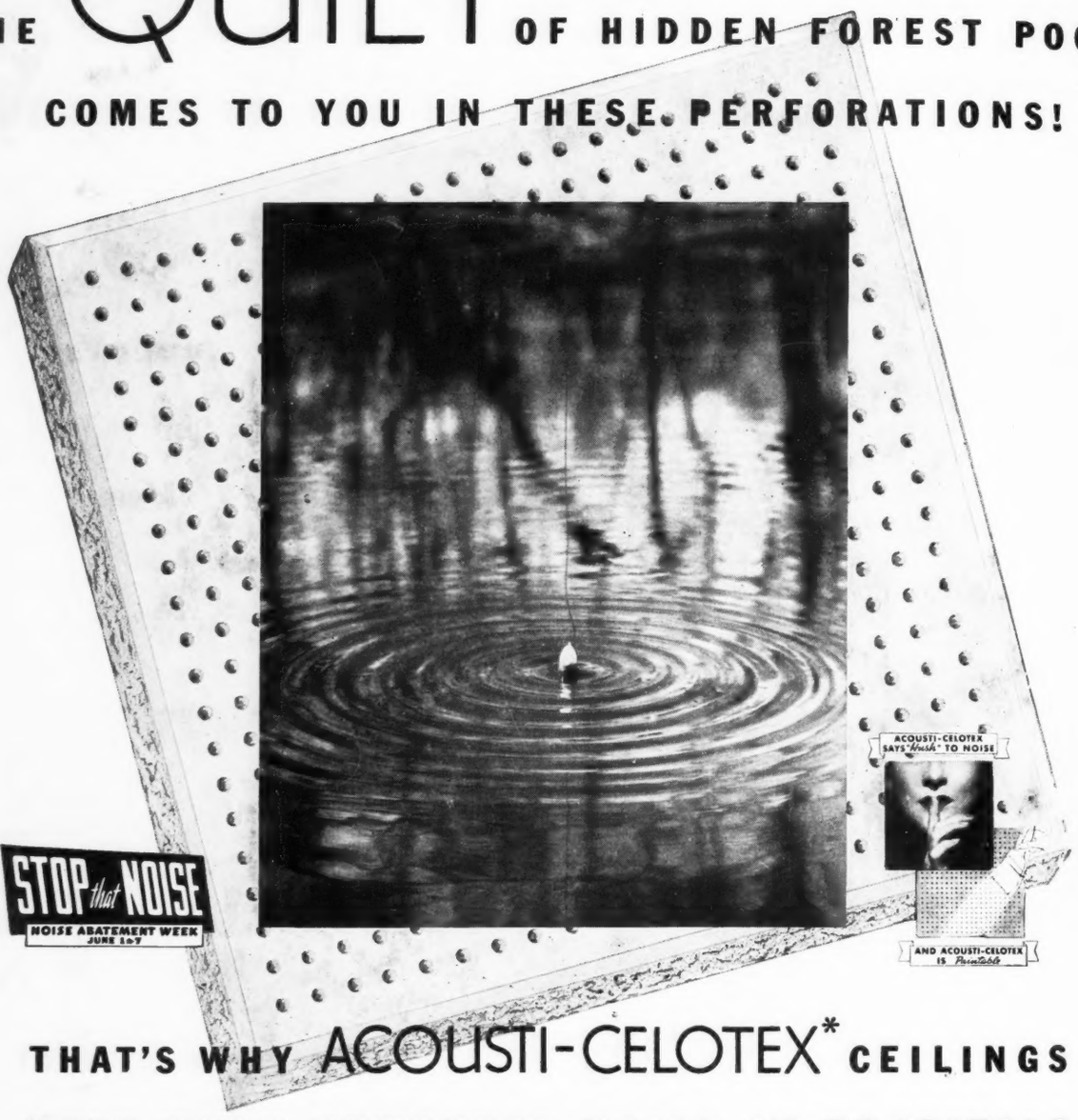

THAT'S WHY ACOUSTI-CELOTEX* CEILINGS HELP HUSH UNWANTED NOISE IN HOSPITALS

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**The word Acousti-Celotex is a brand name identifying a patented, perforated acoustical fibre tile marketed by The Celotex Corporation.*

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